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Where the difference lies: Nursing conflict themes and the role of facework tactics in nursing interaction

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Where the difference lies: Nursing conflict themes and the role of facework tactics in nursing interaction

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Where the difference lies: Nursing conflict themes and the role of facework tactics in nursing interaction

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Scholars have described conflict tactics as a means to engage or avoid a conflict, and face tactics as a means of face-saving by way of defense or restoration. While theories of conflict and face flourish, few researchers have sought an explanation of conflict themes within the field of nursing or examined how nurses display face-saving tactics within their conflict interactions. The goal of this study is to identify the connection of these concepts through a qualitative analysis of conflict stories compiled from interviews with licensed floor-nurses. The data is analyzed two ways: first, as conflict themes in stories about nurses' floor/shift work; and secondly, as communicative face tactics used in conjunction with conflict styles as viewed through a nurses' conflict-interaction. The study identified three outcomes. From the analysis of conflict stories, an updated and extended view of conflict themes in nursing is developed. Specific face tactics surfaced within certain conflict themes supporting the concept that face tactics can directly affect the outcome of a conflict interaction. And lastly, the discovery of new restorative and defensive face tactics not previously

identified in research literature. The implications for theory and practical application are also discussed, as is the proposed direction for future research.

Keywords: Facework, face tactics, face negotiation, nursing conflict, conflict narratives in nursing, conflict themes.

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Chapter One: Introduction and Purpose

As two nurses were working together to give a young patient his injections, the RN immediately noticed that the younger LVN was not aspirating the syringe on the child prior to injecting the vaccine. Concerned about possibly injecting the vaccine directly into the bloodstream, the RN asked the LVN to step outside. Asked why she did not aspirate, the LVN replied that injection procedures had changed since the RN was in nursing school. No longer was it necessary to aspirate, enabling a nurse to handle more patients in less time. As the probability of injecting the vaccine into the bloodstream was negligible, the once-taught procedure was overturned for speed and efficiency. This confused the RN. It went against her education and understanding of patient safety. Both nurses became defensive when challenged on what they had learned and practiced. Of greater importance was their competing understanding of 'safe practice'. When they re-entered the patient room, tension between the two was obvious, both avoiding conversation with the other.
(As told by participant Juliet).

What causes an employee to exhibit signs of worker frustration, signs of lost identity within the workplace or signs of failure to connect with other team members? These questions are at the heart of understanding workplace and workgroup dynamics. Sociologists and anthropologists have analyzed changes in the workplace as the work culture intertwines with various types of workers. Organizational behavior authors have added that each culture builds its own identity - that operates and communicates under its own cultural rules and standards (Zemke, Raines & Filipczak, 2000). Communication scholars, along with their associates in anthropology and sociology, have actively analyzed workplace discourse, exchanges and interaction. Not until the early 1980s was there an integration of these disciplines combining culture and communication. As generations of workers remain in the workplace longer, researchers started analyzing

communication styles between different workers more aggressively (e.g., McCann & Giles, 2004; Giles, 1999). Such studies offered numerous insights into age diversity and communication, most commonly focused on job performance (Vecchio, 1993). Wilson (1992), writing on conflict and face negotiation pointed out that facework had primarily been viewed through an ethnic lens (Wilson, 1992).

Facework is a key element of interpersonal communication and has been studied in the workplace, primarily in the context of ethnic diversity. It is relevant to relationships and to status, there is robust theory and research on facework, and thus facework will be the focus of this research on interaction in one work setting, the nursing floor. For much of the 20th century, ethnic diversity was the primary focus of writings on conflict in the nursing profession. Age and experience, though, have played an increasingly important role in practical writings about nursing conflicts (Swearingen & Liberman, 2004); yet analysis of face tactics and strategies between different work groups is virtually non-existent, thus making it a ripe locus of study of face in interaction.

The nursing profession is comprised of multiple groups with representatives segmented by everything from age to practice to experience to education. Older nurses, some in their 60s and 70s, work alongside younger employees (Smith-Trudeau, 2001) who have identical skills. Associate degree nurses (ADN) work with bachelor degree nurses and while both are licensed as registered nurses, they often have noticeably different levels of training. This mixed workforce, an environment of conflict (Peplau, 1953a), provides fertile ground for research. Even within the same organization, different groups view the work experience in different ways. This is particularly apparent in 21st century healthcare institutions where up to four generations of nurses might work the

same shift (Duchscher & Cowin, 2004). Recently, nursing industry and professional publications have devoted considerable attention to nursing conflicts (e.g., Swearingen & Liberman, 2004) as various groups of nurses compete for power and control (Adams & Bond, 2000). Regarding just the issue of age, the consensus is that nurses of differing generations simply do not understand each other. As the middle aged nurses are perplexed by the behavior of younger nurses; the younger nurses are mystified by the practices of the older nurses. Older nurses, eldest on the nursing ladder, are confused by everyone (Swearingen & Liberman, 2004). Nursing professionals believe that such situations demand attention as confusion and conflict directly affect productivity, staff turnover (Smith-Trudeau, 2001; Swearingen & Liberman, 2004) and the quality of patient care (Cox, 2003). These conditions are believed to result in monetary and personnel losses (Antonazzo et al., 2003; Barney, 2002) that damage the institutions where they occur. Industry literature tells us that when healthcare teams work together in harmony, satisfaction grows among patients and staff members. When they do not, interpersonal conflict, role misunderstandings and hierarchical differences cause problems and degrades service (Thornton, McCoy & Baldwin, 1980).

Scope of the Problem

More than 30% of American nurses are working outside of their industry, a larger than normal number according to the American Nursing Association. The percentage has grown significantly over the past twenty years with more nurses leaving the industry over job dissatisfaction (Worobey & Cummings, 1984). Though much of this dissatisfaction is related to interpersonal conflict and disputes, no study has focused specifically on its effect on intra/intergroup nursing conflict (Cox, 2003). In nursing, there are several

components that can lead to interpersonal cultural conflict: different educational backgrounds; different career patterns or goals; semantic differences; class differences; ethnic differences; and differences in generational values or focus (Kreps & Thornton, 1992). While the cited listing is more than fifteen years old, its findings remain widely cited in nursing literature.

A simple search of articles in the Science Direct database reveals over 200 journal articles describing various modes of conflict in nursing disciplines. An older, still widely cited study by Morse and Piland (1981) ranked nurse-to-nurse conflict management third in a list of communication competencies defined as "most important" by the profession (see Appendix A). Communication conflict is not a new development. As far back as 1984, younger nurses leaving the profession pointed to a lack of interaction communication skills as a common cause of disputes and a major factor in their departure (Worobey & Cummings, 1984). From a review of professional literature, this condition appears to have shown improvement in recent years, though the upward trend in nursing departures continues.

The scenario depicted at the start of this section describes an actual incident in which employees involved in an altercation emerged from the conflict bewildered, perplexed and angry over a misunderstanding largely attributable to age and training differences. Coupled with the demand for required teamwork, these nurses moved from a cooperative event into a combative, competitive approach to patient care which led to interactional avoidance. Facework, as a means of maintaining or restoring the relationship, is all but absent in this conflict scenario. Had restorative facework played a great part in the event, the outcome may or may not have changed. But it is clear that, in

medical interaction, uncertainties can only be resolved through mutual agreement and collaboration (Poole & Read, 2003). Facework provides a means of communication between opposing parties (Wilson, 1992). The scenario epitomizes nursing conflict consisting of both cultural and practice characteristics that exist within the profession. Understanding the verbal interaction of the culture and the messages created in face and facework tactics are critical to understanding the outcome of a conflict event as it relates to the interaction. This study helps fill the void by providing a better understanding of face tactics and face-saving methods used by nursing professionals.

Purpose of the Study

Choosing different conflict tactics, as explained by Wilmot & Hocker (1998), provides for different levels of engagement or avoidance of a conflict. Engagement includes decisions to defend and/or restore face, or to avoid the situation in the hope that the conflict will disappear with time. Facework and face tactics play pivotal roles in maintaining a person's ability to move between different conflict tactics such as avoidance, accommodation, competition, collaboration and compromise. These conflict tactics simultaneously provide an avenue for determining what face tactics a person chooses to employ in the defense or restoration of their existing face, or the creation of a new face.

In the theoretical research of Cupach and Metts (1994) and Scollon & Scollon (2001), the management of face is a catalyst for either the formation or erosion of an interpersonal relationship. The purpose of this study is to examine specific face tactics employed by nurses in a healthcare environment as they attempt to defend, restore or save face with a fellow nurse. Specifically, the study looks at conflict interaction and how

the interaction leads to nurses' conflict behavior in work relationships. Given the industry/professional focus on conflicts arising from interactions between nurses of different groups (age, practice, education and experience), the participants were selected to reflect differences.

This study provides a framework for understanding face among nurses, possibly providing value to a wider range of organizations. For the general worker, the study reveals how normal face tactics are perceived by peers. For nurses, this study provides a more thorough examination of face tactics and asks important questions. Is facework a factor in the nurses' perception of conflict management? How do face tactics and face maintenance play a role in conflict interaction and job satisfaction? By answering these questions, we can help to alleviate frustration and, ideally, prevent early exit from the profession. Additionally, the study may provide a benefit to the healthcare patient as it explores how patients fare in the midst of conflict exchanges between their healthcare providers. By researching facework we may affect outcomes of health-related conflicts and possibly secure better outcomes.

In spite of the fact that the nursing profession gives great importance to this topic, it has not received the attention of many researchers. Wilson's (1992) question remains unanswered: "How does culture influence the role of face and facework in negotiation?" (p. 200). By extension, how does face and facework directly influence the outcome of a negotiated conflict interaction (Wilson, 1992)?

Chapter Two: Literature Review

Overview

Research has shown that conflict, face and facework occur universally within and across cultures. Intercultural face research explains that when communicating with those different from ourselves, it becomes increasingly difficult to draw conclusions about meanings from the interaction (Scollon & Scollon, 2001). Realizing that conflict behavior is a component of this interaction, the use of face action is an attempt to protect the individual and his or her goals and interests by honoring or attacking the other party. This action may relieve or exacerbate the conflict (Ting-Toomey & Kurogi, 1998). A conflict often involves the miscommunication of incompatible identity, relational and/or process issues that require face and facework to move them beyond the current conflict state and into a management stage (Wilmot & Hocker, 1998; Ting-Toomey, 1997; Ting-Toomey & Kurogi, 1998). Such actions become apparent as conflicts emerge in group dialogue and individuals attempt to interpret the thoughts and motives of others. Problems arise as members of each group attempt to use their own cultural standards to analyze and interpret the actions of another group. If the same standards do not guide both groups, a cross-functioning discord may result when the group experiences a false sense that everyone else acts and responds the same way as they do (Dubinskas, 1992).

This review will examine how face and facework relate to conflict and how their use impacts cultural differences (age, experience/tenure, education and practice) in communication. Topics covered include: conflict; personal identity; face/facework; and nursing as it relates to conflicts. From this review, I have compiled a comprehensive

look (along with supporting tables and figures) at conflict themes and facework as a means to conflict management between modern day nurses.

Conflict

Scholars view communication as a manifestation phase of conflict. Just as fever may signal an illness, communication can be an indication of the existence of an impending conflict that occurs through the social strategies and tactics used by the involved parties (Putnam, 2006). A generally accepted definition of conflict is an expressed struggle or effort involving more than a single party that is interdependent upon each other and maintains incompatible goals with possible interference (Folger, Poole & Stutman, 2005; Hocker & Wilmot, 1978). From an extensive literature review by Fink (1968), a working definition of conflict (e.g., social) would be: "any social situation or process in which two of more social entities are linked by at least one form of antagonistic psychological relations or at least one form of antagonistic interaction" (p. 456). And for Hunter (1994), conflict is related to group and culture as it occurs when there is a polarization of groups and the ways in which they perceive each other and their actions.

Workgroup conflict causes disruption in operation and potential breakdowns that can eventually reduce job performance and make members dissatisfied, frustrated and generally unhappy with their function (Poole & Garner, 2006). Diversity can play a major role in a workgroup conflict. Garcia-Prieto et al. (2003) explains that conflict can arise from different social categories within a workgroup where there is a perceived opposition to other individuals within the group. These diversities contribute to the social and personal identity of the group members (see section: Identity) (Garcia-Prieto et

al., 2003) and are the catalyst for over 50% of the conflicts within the group (Ayoko et al., 2002). Additional research finds that diversity-related characteristics like age, race, education and gender can contribute to relational and emotional conflict and negatively affect the performance of the workgroup or members ultimately defining how the group or individual manages overall conflict (Poole & Garner, 2006). As a critical development-process, the actual conflict event can provide an avenue for a creative work-process that addresses the member's needs while avoiding the stagnation or "stuck" stance common in a conflict stage (Poole & Garner, 2006). Sand, Stafford & McClelland (1990) found that, to create this active-member affect, the member or group needs to act quickly to reach consensus with others before stagnation occurs.

Mortensen (1991) maintains that language and communication play significant roles in recognizing and understanding the evolution and development of a conflict. This is supported by Ruben (1978) who notes that, while communication and conflict can act independently of one another, they simultaneously define each other, making them interdependent. "The most critical confusion has been equating conflict with competition" a view that has been regarded in the past as viewing conflict terms of opposing interest (Tjosvold, 2008, p.24). And, though early scholars viewed conflict as a negative-but-necessary force within communication and interpersonal relationships, this changed in the 1960's when the concept of 'resolution' was emphasized as a necessary requirement to meet both interpersonal and organizational goals (Mathur & Sayeed, 1983). Scholars continue to recognize conflict as a means to create a positive and healthy aspect that promotes cohesiveness (Coser, 1956), maintains power balance

(Blake, Shepard & Mouton, 1964), creates change (Litterer, 1966) and enables creative problem-solving (Hall, 1969).

Conflict may also be defined as a grouping of behaviors (Van de Vliert, Euwema & Huismans, 1995) all working together to accomplish a single task based upon the concern for people or the concern for results within a situation (Blake & Mouton, 1964). Though previous models incorporated only five categories (as in Blake & Mouton's 1964 model of competing, collaborating, compromising, accommodating and avoiding), Van de Vliert et al. (1995) created a seven-characteristics model as seen in Table 2.1. In this model, Van de Vliert subdivides the "competitive" behavior into "forcing, confronting and controlling" (p. 273) creating his seven characteristics to describe conflict behavior. This model can be relevant in analyzing face tactics and is a source for the face behavior types displayed in Table 2.2, a set of descriptions used in the participant interview process (see Appendix H).

Table 2.1

Seven characteristics of conflict behavior

Forcing	Undermining organization, contending of the other party in a direct way
Confronting	Demanding attention to an issue
Process Controlling	Dominating the issue to one's own benefit. Competing.
Problem Solving	Collaborating to resolve the issue to mutual benefit
Compromising	Settling upon concessions, or conceding
Accommodating	Giving in to the other party
Avoiding	Moving away or ignoring the issue

(As derived from Van de Vliert et al., 1995)

The Van de Vliert model promotes the concept that conflict is an integral part of personal or employee identity as it relates to goal attainment. These seven characteristics of behavior, also referred to as the "locus of face" are critical to the understanding of face and facework in determining an individual's interest and ultimate delivery of the message (Rogan & Hammer, 1994; Ting-Toomey, 2004; Ting-Toomey & Kurogi, 1998). According to Rogan & Hammer (1994), the ability to negotiate one's message is based upon face, determining how the individual directs his attention in a conflict interaction to the concern for self, others or both. Face honoring and face threat emerge from this "locus of concern"; their effect is defined by face valence—the process by which face is defended or saved, maintained or upgraded and the rigor the individual uses to maintain or honor face. When threat or honor of face is presented, facework temporality strategies are incorporated to manage potential defense or restoration through facework communication strategies (Ting-Toomey, 2004). These facework communication strategies can be extensive and numerous in defending and restoring face (as later displayed in Table 2.3).

What do these elements tell us? They tell us that conflict does occur and that people exhibit different behavior in the conflict interaction (Blake & Mouton, 1964). They tell us that personal identity and goal attainment play an integral role in conflict behavior. We understand that conflict can be a catalyst for facework and face tactics. However, still unstudied in the conflict arena are the behaviors and interaction styles of different cultural groups (age/generations, education, experience and practice) as they relate to each other in professional settings. Regarding age, while family conflict between generations has been reviewed by authors such as Tannen (e.g., Tannen, 2001),

few studies have analyzed the age/generational gap that may exist between individuals or their workgroups and how face plays a role in conflict interaction.

Identity

"From the time we are born and given a name by our parents, we are inextricably dependent on others to play a part in how we define ourselves and why we define ourselves as we do. Consequently, our identities are shaped and molded during interactions with others. We use others as a guidepost for normative behavior and we also set up implicit and sometimes explicit "contracts" with other [individuals and groups], which indicate how we will progress with our relationship" (Jackson, 2002, p. 360).

In considering identity, communication is a risk not only to the speaker's face, but to the receiver's (Scollon & Scollon, 2001). In each encounter of face, individuals maintain two faces: one wants to be involved in interactions with others showing them a level of involvement; the other desires autonomy and independence. As both aspects of face are simultaneous, the faces show support for the other participant's views while emphasizing individuality by withdrawing—an act that prevents dominance from the other party (Scollon & Scollon, 1983, 1994, 2001). This concept relates directly to identity—specifically personal identity—in that basic human needs affect both the individual's self-esteem and self-enhancement (Smyth, 2002).

Personal identity is a complex concept, one that goes beyond the study of communication and has elements connected with the psychology, sociology and philosophy of the individual (Scollon & Scollon, 2001). When a person encounters a conflict, personal identity becomes emotionally charged. This state impacts how the

person interacts with the organization and fellow members of the profession (Brown, 2000). The more the person becomes involved with the conflict, the more he personally identifies with the idea/concept of the conflict. He may perceive any attack on an idea as an attack on his personal self, creating a defensive environment (Pemberton, 1983). It is not the identities *per se* of the conflict but rather the values, beliefs, norms and demands of the identity that join together to form the conflict (Ashforth & Mael, 1989). This is key as values, beliefs and norms are also characteristics used to define a culture. Deetz et al. (2000) defines culture as the values and assumptions that help the individual define his existence, to be part of a greater whole and identify a personal identity which can be related to others. From this position in conflict, the individual may conclude that his personal objectives may not be attained. Or, as Rubin and Pruitt (1994) point out, the conflict at this juncture becomes the individual's reaction to potentially failed aspirations. At this point, facework will occur as the individual attempts to maintain his identity.

Tajfel (1978) and Tajfel and Turner (1986) contend that an individual's identity is comprised of his personal identity and his social identity. Personal identity is defined as personal characteristics—likes, dislikes and idiosyncrasies—while social identity is comprised of affiliations or associations within particular groups. Affiliation is supported when, as a member, the individual seeks to be considered "in-group" by means of his actions and characteristics. These actions contribute to building the individual's self-esteem, stemming from a sense of belonging to the in-group or culture (Tajfel & Turner, 1979, 1986). The effect is enhanced by the subsequent denial of the characteristics of the out-group (Branscombe & Wann, 1994; Finchilescu, 1986; Oakes & Turner, 1980).

Relating groups to identity, when one group or group member attempts to compare itself to another group, the member or group is attempting to achieve a sense of positive identity (Tajfel, 1978). This sense of positive identity; however, can result in discrimination, favoring the in-group while holding a negative feeling toward the out-group (Tajfel, 1978). Linville (1982), however, found differently. Linville discovered that people will evaluate an out-group member more severely than an in-group member. Specifically, when the information shared is of a positive nature, the out-group member would receive a more favorable rating than one bestowed on an in-group member. When the information is negative in nature, the opposite occurs—out-group members receive less favor than the in-group. Therefore, bias toward any group is directionally dependent on the favorability of the information about the group (Linville, 1982).

Studying facework as a means of defense, researchers in Social Identity Theory have paid particular attention to how identities are managed through group attitudes and communication. Communication Accommodation Theory (CAT) explores methods and ways that individuals adjust their speech based on group and interpersonal factors. Regarding age, Coupland , Coupland, Giles & Henwood (1991) determined that interpersonal relations can reflect how individuals negotiate their identity through the dynamics of intergenerational conversation. As individuals attempt to communicate to out-groups, they adjust their communication style to accommodate the other party—but only when they desire to create a positive or inclusive relation with the other group or individual. When this relation is not sought, distance is created (Williams & Harwood, 2004). Relatable to Hewstone and Brown (1986) in their intergroup contact theory, identity becomes a relevant factor within intergroup communication.

Face, Facework and Face Acts Tactics

Face can be traced back to China in the 4th century B.C. (Hu, 1944; Ho, 1976) with the development of two aspects: *mien-tzu*, a social image and reputation developed by the growing and maturing through life; and *lien*, the moral worth of an individual described by his or her character. Both aspects are directly related to the ultimate reputation of the individual (Hu, 1944). Deutsch expands this understanding of face by referring to it as "one of an individual's most sacred possessions" (1961, p. 897), a necessary element for sustaining an individual's self –esteem (White et al, 2004). Therefore, face has become attractive to communication scholars as it opens up the question of who is the real person under the face that is presented in the interaction (Scollon & Scollon, 2001).

Theorist Erving Goffman (1955) defines face as "the positive social value a person effectively claims for himself by the lines [the pattern the person portrays as the version of the situation, others or view of self] others assume he has taken during a particular contact". Face is "an image of self delineation in terms of approved social attributes" (p. 213), an image of the self seen by others as attached to an individual and defined by circumstances within a situation (Ting-Toomey & Kurogi, 1998). For Goffman, an individual's concern for face revolves around his desire to remain in a positive light (Goffman, 1967; Rogan & Hammer, 1994). This aspect of face considers the feeling and worth that the individual places on others in a given situation (Ting-Toomey & Kurogi, 1998) and how the individual reacts to that situation, to his current face, and to the face of others. Facework is the action the individual takes in presenting

the image of face, saving face, protecting or defending face, including being poised to face threats and the possibility of loss of face (Goffman, 1955).

Ting-Toomey and Kurogi (1998) determined face to be a sense of social self-worth, one that the individual desires others to see. Ting-Toomey envisions face as a cultural-specific lens that can enhance and complement the social self or create conflict due to miscommunication over incompatible identity, relationships or processes to protect the individual's self-interest. This self interest can be viewed as a means of fellowship or the desire to be included in membership. In addition, it can also be viewed as autonomous—a means of opposing influence from others to remain independent from other cultures (Lim & Bowers, 1991).

Pulling together the concept of identity and face, Cupach and Imahori (1993) view face as an extension of a person's identity, specifically in the presentation of face within conflict. In encountering another group's member, the individual will rely upon the knowledge of the other, including the individual's own interpretation, elaboration and recollection of information about the other group based upon preexisting theories and key characteristics of that group (Linville, 1982). This may include imposing their external identities and culture upon the other person, resulting in face-threatening acts (Gudykunst, Lee, Nishida & Ogawa, 2005).

Five face behavior styles have been identified that place an individual's conflict management style within the framework of two dimensions: concern for self, and concern for others (Blake & Mouton, 1964; Rahim, 1983, 1992; Thomas & Kilmann, 1974; Van de Vliert et al., 1995). From these five styles, Oetzel et al. (2000) constructed a listing of typological categories (see Table 2.2) that reflect face behavior during a conflict event.

Table 2.2

Typology of face behavior

Typology of Face Behavior
Abuse – verbal assaults
Apologies – admits mistakes
Avoid
Compromise
Confronts
Consider others – inquires and questions
Defend self
Discusses problem & solution – as in confronting
Expresses feelings
Forces issues – as in controlling
Gives in and accommodates
Holds private discussion
Involves third party
Passive aggressive
Pretends – hides or does not acknowledge conflict
Remains calm

(Derived from Oetzel et al., 2000)

These behaviors reside within the five conflict-behavior categories: compete, compromise, accommodate, avoid and collaborate (Blake & Mouton, 1964). "Expressed feelings" and "involves third party," actions that Ting-Toomey (2005) calls "new conflict categories," are not found within traditional research in conflict behavior.

Brown and Levinson (1978) developed politeness theory to examine face wants, how face works, facework strategies and how situations can effectively influence face. Politeness theory looks at both positive face—the desire for approval by others, and negative face—the desire to not be impeded by others (Brown & Levinson, 1978), bringing together identity concerns, situational influences, and discourse strategies (Brown & Levinson, 1978; Tracy, 1990). Reactions to these concerns, influences and strategies are referred to as 'facework', the concept of combined communication skills

used to support, defend, and challenge a person's face (Ting-Toomey & Kurogi, 1998) against face threat acts (FTA) to oneself and to others (Cupach & Metts, 1994). Wilson (1992) sees face-threatening acts as isolated to only one type of face at a time (e.g., a threat to the positive face, but not the negative face). These threats manifest in the form of requests, orders, offers and overt threats to the hearer's autonomy. Criticisms, accusations, and noncooperation become intrinsic threats to the need of approval by the positive face (Wilson, 1992).

Brown and Levinson (1978) build on this premise, noting that the defense of one's face may also protect or restore the other party's face (Wilson, 1992). The process moves the individual from the position Goffman (1955, 1967) refers to as *wrong face* back into the desired position of *in-face*, restoring the desired identity of the individual in the eyes of the other party (Merkin, 2006). Goffman uses this aspect of facework to describe a positive *in-face* mode (defined by a level of confidence and assurance) and a *wrong-face* mode (as when information is being communicated in a way that precludes integration with the desired communicated *line* [image]). If face is threatened and the individual is placed into wrong-face, facework is accomplished by either an action by the individual in the wrong-face to regain in-face, or by an action of the threatening party (Goffman, 1967).

In some instances, the wrong-faced individual moves into *lose-face* (or *shamefaced)* due to a failure to maintain a social status/level expected by others (Goffman 1955, 1967). With the loss of face comes a possible loss of self-esteem and social approval (Deutsch & Krauss, 1962). When attempting to negotiate and/or regain face, the loss of face creates problems like unwarranted intimidation, the casting of

doubts, questioning of the individual and a reduction in status in the eyes of others (Brown, 1977). Although not irreversible, loss of face (Ho, 1976) can severely hamper the negotiation abilities of an individual and his ability to achieve future desired outcomes (Wilson, 1992). To regain or save face, the individual must be able to sustain an impression that is acceptable to others, one seen as consistent with an appropriate in-face model (Goffman, 1967). To do this is to *save-face,* demonstrating that the individual has moved beyond *lose-face* and remains *in-face* (Goffman, 1967). Such face saving techniques can be classified as protective (defensive) or restorative (corrective) tactics.

There is no lack of research on protective and restorative tactics as various scholars have derived long lists of face tactics from their research of the topic. I have extracted from the literature a comprehensive list of the tactics and characteristics used to protect and restore face as identified by numerous theorists. These findings are displayed in Table 2.3 and again repeated in Appendix O in a more categorical format with additional face tactics identified in the research of this dissertation.

In developing the list in Table 2.3, I collected the face tactics from the original theorist and placed the tactic into one of two macro-categories, restorative or defensive, as defined by the theorist. My placement was in no defined order. With certain face tactics the theorist created sub-categories that I noted in the table (e.g., Cupach and Metts' sub-category 'fading away' and 'negotiated farewell' to the category 'withdrawal'). Selected theorist created a third categorical level (e.g., Sillars' sub-category 'non-committal remarks' in the macro- level 'avoidance' is further divided into 'non-committal statements', 'non-committal questions', and 'procedural remarks').

After the listing of the categories, I provided an explanation and/or example of the face tactic. When present in the literature, I abstracted the explanation or example of the face tactic from the original theorist. If not present I created the explanation or example based upon my understanding of how the theorist viewed and identified the face tactic. The final column in the table identifies the original theorist of the face tactic.

These same face tactics have been recreated in Appendix O; however, this new listing also categorizes the face tactics by a second macro-category. As the first category is defensive or restorative, the second category is a conflict management style as developed by Blake and Mouton (1964). These conflict management styles are derived from the literature; however, categorizing the various face tactics under these styles was not provided by the original theorist. Therefore, I subjectively arranged the face tactics under the conflict management styles to allow for easy recognition of the tactic when analyzing conflict quotations and excerpts.

Table 2.3

Scholarly communicative practices to defend and restore face

Defensive (Protective) Practices			Explanation/Example	Reference
Avoidance				
	Avoiding topics		"Let's talk about it later" "I don't think we should discuss it at the moment"	Cupach and Metts, 1994
	Evasive Remarks		"That could or could not be the case"	Sillars, 1986
	Avoidance Denial			Sillars, 1986
		Direct denial	"That's not my problem"	Sillars, 1986
		Implicit denial	"That's never been a problem before"	Sillars, 1986
	Topic Management		"What about this too"	Sillars, 1986
	Non-Committal Remarks			Sillars, 1986
		Non-committal statement	"So what's the big deal"	Sillars, 1986
		Non-committal question	"So what do you think?" or "I don't understand what you are saying"	Sillars, 1986
		Procedural remarks	"You're not speaking loudly enough" or "Can you say it again so that I can understand you"	Sillars, 1986
Changing topic or subject in conversation	Stream shifting		"Yes, but I remember a time….."	Cupach and Metts, 1994
Pretending to not notice when something FT is done			"Did you say something?"	Cupach and Metts, 1994
Pre-disclosure			Bonding statement - "We're in this together"	Ting-Toomey, 2005 Cupach and Metts, 1994
Pre-apology			"Before we start I want to mention that I …"	Ting-Toomey, 2005 Cupach and Metts, 1994
Enlisting politeness			Using polite comments and gestures. Offering credibility.	Brown and Levinson, 1987

Table 2.3, continued

Resisting intimidation and blame		"Don't try to put it on me."	Folger, Poole & Stutman, 1997
Enlisting disclaimers			
	Hedging	"I may be wrong" or "could it be this instead?"	Hewitt and Stokes, 1975
	Credentialing	Stating one's status - "I have years of experience in …"	Hewitt and Stokes, 1975
	Sin licensing	Indicating that is an acceptable behavior "But everyone is doing it!"	Hewitt and Stokes, 1975
	Cognitive disclaimer	Indicating knowledge of unreasonable behavior. "I know, but it is acceptable"	Hewitt and Stokes, 1975
	Appeal for suspended judgment	"Hear me out before deciding"	Hewitt and Stokes, 1975
Making extreme offers or comments		"Fine. I'll just do it myself"	Wilson, 1992
Using put-downs, insults, degrading comments or threats		"I'll just take care of it since you obviously can't"	Tjosvold, 1974
Blocking goals			
	Blocking opponent's goals	"You wait for me before you do anything" "My way comes first!"	Tjosvold, 1977a, 1977b
Uncooperative behavior		"Maybe later when I feel like it"	Tjosvold, 1977a, 1977b; Cupach and Metts, 1994; Wilson, 1992
Competitive			
	Hostile Jokes and statements	"So what are you really trying to say?"	Sillars, 1986
	Hostile Question	"Who made you perfect" or "So who made you the goddess"	Sillars, 1986
	Rejection	"Oh, come on" or "You're exaggerating"	Sillars, 1986
	Personal Criticism	"Who are you to criticize me"	Sillars, 1986
	Denial of Responsibility	"That's not my fault"	Sillars, 1986
	Presumptive Remarks	"Just get over it"	Sillars, 1986

Table 2.3, continued

Withdrawal			
	Fading Away (Indirect)	Slowly disappearing from the scene or the conflict interaction	Cupach and Metts, 1994
	Negotiated Farewell (Direct)	Termination of relationship or contact. "I think it is time for me to leave" or "If you feel that way, I'll just go away."	Cupach and Metts, 1994
Returning blame and blame shifting		"Maybe I did, but you did it too" or "Do you know what he did?"	Similar to Passive Aggression from Ting-Toomey, 2005
Responses			
	Apology	"I'm really sorry I did that"	Cupach and Metts, 1994
	Justification	"This is the way I was taught to do it" or "no one else could do it."	Cupach and Metts, 1994
	Refusal/denial	"I didn't do it"	Cupach and Metts, 1994
	Soothing	"Yes, you have every right to be angry"	Cupach and Metts, 1994
	Relational Work	A sense of hope. "I think we can work this out"	Cupach and Metts, 1994
	Relational Ritual	Flowers, cakes or other gifts	Cupach and Metts, 1994
	Affective State	Crying, running away, pouting, joy, laughter and other visible states	Cupach and Metts, 1994
	Impression Management	"Not even close"	Cupach and Metts, 1994
	Excuses	"I didn't know that it was wrong to do that"	Cupach and Metts, 1994
	Truth	Providing truth. "I tried to be totally honest with you"	Cupach and Metts, 1994
Restorative (Corrective) Practices		Explanation/Example	Reference
Humor and Laughter		Laughing, irony or humor	Argyle et al., 1981
Physically fleeing		Removing self from the situation	Cupach and Metts, 1994
Direct Aggression		Screaming and yelling. Possible physical violence,	Ting-Toomey, 2005 Cupach and Metts, 1994

Table 2.3, continued

Passive Aggression			Denial, forgetfulness, acting confused, blaming, sarcasm, non-verbal actions as sulking and pouting "I don't remember that"	Ting-Toomey, 2005
Avoidance			Avoiding or delaying the further discussion of the act "I need to handle this first…I'll think about it"	Ting-Toomey, 2005 Cupach and Metts, 1994
Apologies				
	Traditional Apologies		"I'm sorry"	Goffman, 1967
Physical remediation			Adjusting clothes, cleaning up, etc…	Metts and Cupach, 1989; Semin and Manstead, 1982
Accounts				
	Quasi-theories	Adages and simple explanations	"It's Murphy's Law!"	Folger, Poole & Stutman, 1997
	Remedy	Offers of reparation	"Would it help if I paid for it?"	Folger, Poole & Stutman, 1997
	Conversational Repairs	Corrects or restates issue	"What I said was that I was not going to come."	Folger, Poole & Stutman, 1997
	Excuses			Semin and Manstead, 1983
		Denial of intent	"It was an accident"	Semin and Manstead, 1983
		Denial of violation	"I was tired"	Semin and Manstead, 1983
		Denial of agency	"It wasn't me"	Semin and Manstead, 1983
	Justification			Semin and Manstead, 1983
		Claim of event misrepresentation	"That's not what happened"	Semin and Manstead, 1983
		Principle of retribution	"He deserved it"	Semin and Manstead, 1983
		Social comparison	"Other people do it"	Semin and Manstead, 1983
		Appeal of authority	"I was told to"	Semin and Manstead, 1983
		Self-fulfillment	"It made me feel good"	Semin and Manstead, 1983
		Appeal to utilitarianism	"The benefit outweighed the harm"	Semin and Manstead, 1983

Table 2.3, continued

		Appeal to value, logic and reason	"It was the right thing to do"	Semin and Manstead, 1983
		Appeal to face	"I wanted to feel credible"	Semin and Manstead, 1983
Aggravation-Mitigation	Threats		"Don't make me get a supervisor"	Labov and Fanshel, 1977
Compromising				
	Appeal to Fairness		"You got your way last time"	Sillars, 1986 Raush, et al, 1974
	Suggested Trade-offs		"I'll do this if you do that"	Sillars, 1986
Collaborative				
	Conventional Remarks	Fact finding statements	"What do you think I did wrong?"	Raush, et al, 1974
	Agreement or acceptance	Agreeing or acceptance fault of the offense	"You're right!"	Gottman, 1979
	Conciliatory Remarks			
		Supportive Remarks	"I can see why you're upset"	Sillars, 1986
		Concession Remarks	"I will do better next time"	Sillars, 1986
		Acceptance of combined responsibility	"I think we both contributed to the problem"	Sillars, 1986
	Analytic Remarks			
		Disclosing statement	"I was really having a bad day	Sillars, 1986
		Qualifying statement	"It was due to staff shortages"	Sillars, 1986
		Solicitation of disclosure	"What were you thinking of?" or "Is something going on here?"	Sillars, 1986
		Solicitation of criticism	"Why does this bother you?"	Sillars, 1986
Accommodative				
	Desire for harmony		"It's OK, don't worry about it" or "It upsets me when we argue"	Sillars, 1986
Personal Idioms				Bell et al., 1987
	Confrontation		"I'm going out on a limb" "Whose neck is on the line anyway?" "This is nothing but a bunch of monkey business"	Bell et al., 1987

Table 2.3, continued

	Expression of affection	"Now there, there"	Bell et al., 1987
	Labeling	"Spoiled, rotten child" "That's so gay"	Bell et al., 1987
	Nicknames	"The old man" "Newbie" "Sacred cow"	Bell et al., 1987
	Request	"Let's get back on track" or "Don't keep me in the dark"	Bell et al., 1987
	Sexual references & invitations	"You give me the tingles" "Looking good!"	Bell et al., 1987
	Teasing insults	"You be new to the game" "Still trying to figure it out?"	Bell et al., 1987

As displayed in Table 2.3, defensive and protective practices are used to deter threats upon one's own face (Tracy, 1990) and/or minimize the threat to the other's face (Goffman, 1959; Tracy, 1990). Restorative and corrective practices associate with the individual's effort to repair a damaged face or to move from a loss of face back to in-face (Goffman, 1955).

Facework has the unique power of creating or revising an identity. By creating or re-creating an identity, facework includes: face-honoring as an expression of pleasantness; face-compensation as a measure of apology; face-neutral mode as a means of communicating or expressing emotion about a third party previously affected by face; and face-threats, expressing attack or negative emotion upon the other (Shimanoff, 1985). Each of these acts can effectively change the identity of the party or parties. However, the change may be constrained by the individual's culture, situation or personality. Personality concerns must contain the ability to desire, enact, or wish for an effective change of identity (Tracy, 1990). All face changes encounter the concept of competition and cooperation between the parties and the parties' face (Craig, Tracy & Spisak, 1986).

Therefore, to appropriately change the identity of the party, the issue of competition or cooperation surfaces to ensure an effective change of face; otherwise, the interaction can become face-threatening and result in an impasse (Tracy, 1990).

Facework Tactics and Negotiation

Medical work, by its nature, encourages negotiation. Elements like the field's complexity, the uncertainty of the work and decisions that only can be resolved through mutual agreement require a level of negotiation among health care team members (Poole & Real, 2003). The negotiation process is complicated by temporary team members, continual staff turnover, uncertain boundaries within the practice and the constant struggle to clarify role expectations (Poole & Real, 2003). Therefore, the process of negotiating face plays a major role in conflict interaction (Brown, 1977; Deutsch, 1973; Folger & Poole, 1984; Pruitt & Smith, 1981; Tjosvold, 1983) as does the process of avoiding the loss of face (Brown, 1977).

Researchers analyzing facework negotiation have examined the concept from a social-psychological. This avenue of human psychology includes the dynamics of the individual's (or group's) face-to-face interactions as they relate to the context of social discourse interaction. Entering into face negotiation, the social-psychological view of the interaction can present a perceived incompatibility between parties as they look for various strategies and tactics to create a mutual solution (Putnam & Roloff, 1992). A balance of power between the parties creates cooperation (Folger & Poole, 1984), and trust, enhancing the possible outcome and creating a value-driven negotiation (Donohue & Ramesh, 1992). This trust surfaces from the parties' commitment, indebtedness and interdependence on each other (Greenhalgh, 1987). Even so, as parties enter into the

negotiation, their view of the other, or perceived image, is a major element in their ability to create a face-saving or face restoration during the interaction (Wilson, 1992). Discourse during the negotiation provides a channel of communication between the different face and the needs of the opposing parties. This discourse is viewed in two ways: face directives; and face in the negotiation (Wilson, 1992).

When positive face is approached in a negotiation with a directive, the positive face may be maintained, lost, or even shifted to a negative face. Directives conveyed in an effort to get the other party to uphold certain stipulations already decided upon as pre-conditions, for example, can be used to gain compliance to decisions made prior to the negotiation (Goffman, 1959; Weinstein, 1969; Wilson, 1992). A directive can shift from positive face to negative if the interaction is seen as requesting (or obligating) another party to perform a specific action. Therefore, speech acts can be inherently face-threatening as they act contrary to the wants and desires of the speaker or the hearer (Brown & Levinson, 1987). These speech acts create face threats by accomplishing relational distance, power and cultural ranking between the parties. Parties in an interdependent relationship often attempt to motivate the other or save/restore face (Wilson et al., 1998). Unfortunately, there are speech acts and save/restore face acts that may actually create the reverse. Examples include the positive face scenario where a speaker apologizes and confesses—only to have the hearer hear it as a criticism or insult (e.g., "I'm sorry that I did not understand it was the way you were taught.")

Each time an individual attempts to save/defend or restore face, the individual is negotiating a transformational event. Therefore, it is not incongruous to regard negotiation as an element of face maintenance. When face enters the negotiation, as

elaborated by both Goffman (1955) and Deutsch (1961), face becomes the object of the negotiation. Who is wearing what face? Why are they wearing it? How are they wearing it? When face is not solidified prior to the negotiation (such as when a person does not signify either a positive or negative face), the concept of face lays the ground rules for the negotiation event. Thus, face is no longer considered the objective but the condition for the interaction (Goffman, 1955) (e.g., "Now what are you trying to say?').

Stereotyping and Communication within Negotiation

Alongside traditional negotiation theory is the concept of stereotyping and an examination of negotiation interaction that occurs when stereotyping the other party. This section is included into the literature review as a connection between cultures (as in example of extreme generations - youngest and oldest) and their habits within facework and negotiation.

Stereotyping is a cognitive organization of trait-based information that one person gathers about another and is usually referenced as a social-based membership (Macrae, Stangor & Hewstone, 1996). The communication in a stereotyped interaction may include trait-based representations of the other party or an expectation of the best means of communicating with that party (Harwood, McKee & Lin, 2000). From this communication expectation comes the Communication Predicament of Aging Model (CPM) (Ryan, Giles, Bartolucci, & Henwood, 1986), which involves a perception of conceptual relationship with cognitive and communicative processes to develop an interaction between the two parties. At the heart of the CPM is the concept that one

party stereotypes the other party in a more negative way, creating a lower quality of social interaction and face negotiation (Harwood et al., 2000). In generational studies, this trait-based, stereotyped interaction often leads to patronizing speech directed at the older party by the younger. Such patronizing speech (including simplified vocabulary, speaking slower, etc.) is classified as an over-accommodation style (as from the Communication Accommodation Theory – CAT) (Giles, Coupland & Coupland, 1991; Williams & Harwood, 2004) as opposed to under-accommodation, defined as failing to be sensitive to the communication needs of the other (ignoring, deflecting, etc.) (Williams & Harwood, 2004; Hummert & Ryan, 1996; Ryan et al., 1986). Both CAT and CPM can be launched from physical cues of the individual (such as gray hair or mannerisms) and the context of the person (such as style of clothing) (Williams & Harwood, 2004).

Although stereotyping in cultural, specifically intergenerational communication, is a growing area of research, a conclusion apparent in the research of such scholars as Giles, Harwood and Williams, only limited data exists for interactions outside the "young to elderly" scenario. While current findings are relevant for determining facework negotiation from a young to old perspective, they become problematic as more closely related generations are considered. With the modern emergence of a greater number of generations simultaneously in the workplace, the understanding of these generations—such as their stereotyping and characteristics—can play a vital role in recognizing face saving and restoration methods.

Realizing Generations

Popular literature has made fashionable ventures in categorizing age by distinctiveness. However, in the past few scholarly articles have addressed the roles and characteristics of such different age/generational groups, with the exception of a few articles from the 1980s. Articles from that period largely focused on relationships of older workers and their performance as they remained in, or re-entered, the workforce. More recently in intercultural communication, Scollon & Scollon (2001) clarify the earlier explanation of Longfellow (1978) in their approach to define categories of age groups as an ideology of American individualism. According to both Scollon & Scollon and Longfellow, Americans are divided into four current generations: Authoritarians (born 1914-1928); Depression (1929-1945); Baby Boom (1946-1964); and Infochild (1965-1980). As each generation is defined by the historical events of the time (e.g., Vietnam War for the Baby Boomer), then each generation thinks, socializes and communicates differently from the predecessor or successor. Perhaps each generation pursues a line of communication that meets the current environment and further dictates how the members respond to face and face tactics (see Table 2.4). While obviously such designations do not describe individuals, they provide a heuristic for discourse and understanding of use in interaction, e.g., many people talk as if these categories are real and invoke them as explanations for behavior.

Table 2.4

Longfellow's generations

Generation	Ideology	Discourse	Face
Authoritarians	Individualism	Electronic and Singular-lingualism	High sense of authority
Depression	Independent Self-made	News and obsession with information, Type-A syndrome	Struggle for domination Attitude of respect
Baby Boom	Fractured society Neither enjoyment or self-expression	Keep things moving and distrust of linear arguments	Rise of relationships and groups/ networks. Transition from hierarchical to relationship structure.
Infochild	The postponed generation. Putting off for later.	Technology and computerized	Feeling of competency and equality to other previous generations.

Building on the Longfellow model of generations, Scollen & Scollen (2001) concluded that:

a) Individuals find themselves trapped between goals, ideologies and identities when they communicate.

b) Individuals' communication problems result not from how one generation communicates with itself, but how they communicate with other generations.

c) The differences between the generations are heightened when encountering organizational communication.

d) Within organizations, although all generations may use the same words and phrases, their meanings may have radically different interpretations.

In modern terminology, the phrase 'generation' refers to a joint construct of people born within the same time span who share similar life experiences including certain demographics, who live through specific historic events and have similar early-work experiences (Blythe et al., 2008). These form a cohesiveness of attitude, perspective and unspoken assumptions within their ranks that can be recognized from both outside and within (Alwin, 1997; Turner, 1998; Zemke et al., 2000; Swearingen & Liberman, 2004). Selected articles on the professions of nursing and hospitality attempt to provide insights on the current segregation of the generations, focusing on the groups' commitment to work, values and ethics. Notably, studies of our current culture, which these authors divide into five generations, look at generational work and corresponding conflicts (Gursoy, Maier & Chi, 2008) through a lens of motivation, satisfaction and subsequent behavior (White, 2006). As people come together from different generations, they bring their various perspectives, blending their characteristics and values to form a work environment. This blending of values, characteristics and world views, along with ways of working, talking, and thinking can infect the workforce with an "us vs. them" mentality (Yang & Guy, 2006; Gursoy et al., 2008) (e.g., an in-group vs. out-group scenario) (see Table 2.5). The table below, provided by focus groups in the research of Gursoy, Maier and Chi (2008), represents an abbreviated look at ages, depicted as generational cultures, as an incongruity of the current work environment.

Table 2.5

Abbreviated characteristics of three generations

Characteristics of older workers (1943 – 1960)
- Live to work
- Respect authority and hierarchy in the work place
- Live large and are in charge

Characteristics of middle-age workers (1960 – 1980)
- Respond to instant gratification
- Work to live
- Identify with the lone ranger
- Friends in high places

Characteristics of younger workers (1980+)
- The more the merrier
- Rules are made to be broken
- Here today and gone tomorrow
- Show me the way

(Gursoy et al., 2008, p.451)

To recognize and understand the concept of generations, readers and researchers have had to reference a variety of sources from popular literature (including articles and books) to the popular press (online articles and blogs). These are all very interesting readings, but more based upon opinion than evidence-based research. Recently an increasing amount of empirical studies (peer-review and data based research using rigorous methods) has surfaced (Myers and Sadaghiani, 2010). This new group of empirical research brings definition to the popular labels given to generational categories (Baby Boomers, Gen X, etc…) by developing lists of generational specific traits and characteristics. Whereas in the past, some suggested that these traits and characteristics were the result of an individual's stage of life, the empirical research of Wentworth and Chell (1997) found differently associating the traits more strongly to generational differences (Myers and Sadaghiani, 2010). Later empirical research of Twenge and

colleagues (Twenge and Campbell, 2001; Twenge and Nolen-Hoeksema, 2002; Twenge, 2000) expanded generational research by specifically tracing negative historical events and cultural changes. It was through events, according to Twenge and colleagues, that the children of the 1980's came to develop higher self-esteem and less depression as they enter young adulthood (Myers and Sadaghiani, 2010), a group known today as the Millennials (Smola and Sutton, 2002).

Twenge and colleagues found that situational events could characteristically define a generational group from another. However, more recently McGuire et al. (2007) compared generational groups to each other, detecting noticeable differences. McGuire et al. (2007) comparing Millennials to Baby Boomers discovered that Millennials are not ambitious workaholics who become critical of coworkers that do not share their same work value, but rather are skeptics, working autonomously with a fervent dislike meetings and workgroups (Martin, 2005).

Based upon the research of Greenbaum and Query (1999) that communication differences can directly affect team performance in an organization, Myers and Sadaghiani (2010) concluded that generational team communication is worthy of future empirical study. Through a set of questions Myers and Sadaghiani (2010) proposes future research as: Are certain generational behaviors viewed as opportunities rather than obstacles? Do organizational members modify their communication between generational groups to manage conflict? And, will generational groups adapt or change to meet the other groups?

Nursing as Relating to Conflict and Age

Studies on nursing conflict have appeared in professional literature for over a half century. One of the most recognized scholars in nursing conflict, Hildegard Peplau, published a three part conflict article in 1953. Outlining nursing conflict based upon power, safety and control, Peplau's 1953 research contributes to recent findings that nursing conflict lodges in not one, but many different arenas, from age to education to best practice.

Regarding age conflict, nursing industry literature and nursing websites embrace the generational view of people and assign characteristics to people based on age cohorts as generations. Discussions of what is called "the age challenge" are common, and there is a widespread perception that nursing is laden with generational conflict and difficulties in communicating. A distinguishing element of any intergenerational conflict interaction stems from the unsuccessful transfer of knowledge, skills and resources associated with one generation to the other (Pfeffer, 1992; Turner, 1998). This resistance to transfer fundamental knowledge, information and skills from the generation creates an accumulation of power for that generation, thus becoming a detriment to the other generations (Irwin, 1998, Turner, 1998; Joshi et al, 2010). In generational terms, 24% of working nurses are the eldest (born in 1922-1943), 47% considered old (1943-1960), and 21% considered middle-age (1960-1980) (Swearingen & Liberman, 2004). Scholars in the profession predict that, as this challenge grows, the profession will fail to entice newer generations to maintain careers within the industry, resulting in a worsening of the current nursing shortage (Swearingen & Liberman, 2004). Table 2.6 presents comments from nursing professionals illustrating that age challenge that can lead to generational conflict among nurses (as identified through the research of AORN – Association of

periOperative Registered Nurses). Table 2.7 displays the findings by Halfer & Graf (2006) concerning the downward trend in perceptions of the work experience by recently employed graduated nurses.

Table 2.6

Nursing generations and characteristics

Eldest (1922-1943)	They are fiscally conservative and loyal, have a dedicated work ethic, are respectful of authority, and follow the rules. Their reward is a job well done, and a believer that you must pay your dues as you progress up the ladder. They are often your mediator and mentor. They are overly cautious and inflexible. They will not take a chance without consulting higher authority. They have adjusted slowly to the massive amount of new technology in healthcare. As nurses, they are viewed as archives of clinical knowledge. They are known to reminisce and talk proudly of the "good old days," when, for example, ether was the anesthetic of choice; sponges, needles and gloves were reprocessed. They do not believe in waste.
Old (1943-1960)	They value creativity, love adventure, seek independence and are risk takers. They are willing to work long hours at their jobs and continue until the job is complete. They provide and expect honest feedback and come up with solutions to new and old problems. They often are the staff members you go to first when you need someone to work overtime because you know they will do it. They remember the days before computers and technology and believe in the value of both. You will find them respecting healthcare authority but also questioning it. Most Boomer women are in the profession of nursing because it was a socially acceptable career for women when they were growing up…much like teaching. This group lives to work and many have experienced lay-offs and job cuts with little possibility for advancement. You will find them working late charting from the day's activity and preparing for the next work day.
Middle-age (1960-1980)	They are skeptical of the organization and look very seriously at the value of their career and association memberships. It must produce a future for them, otherwise they will leave. They are comfortable with diversity. They are extremely self-reliant and have grown accustomed to immediate gratification. In the work environment they expect direct answers to questions, challenging projects and immediate feedback. They expect life balance; however, they want it now. They think about the 3PM shift change at 2:30, and become worried about whether their relief will arrive on time. They are comfortable and embrace new technology (e.g., robotics, minimally invasive surgery, stealth technology) and it will entice them to be loyal. They are born to be life-long learners and they thirst for it. They also seek out working conditions that value their talents, creativity, expertise and input. They want clear-cut goals, and crave performance feedback. They are into volunteerism and want to make a difference in the world.
Youngest (1980 +)	This is the digital generation. They are optimistic, inclusive, globally aware and critical thinkers that only see work as having meaning. They are works in progress and will be the future of nursing. They will redefine the discipline and practice. They are more technologically literate than any other generation. Retirement as we know it will not be a reality for them. They will change the meaning of shift work and change jobs every two to four years. Their career path will hopscotch. We are still learning about them.

(Collected and compiled from: McNamara, 2005; Dunn-Cane, Gonzalez & Stewart, 1999)

Table 2.7

Variable mean scores of work perception satisfaction of recently graduated nursing students

Variable	3 Months	6 Months	12 Months
Knowledge and skills to perform job	3.21	3.35	3.42
Access to resources	3.29	3.30	3.37
Ability to participate in professional development opportunities	2.88	2.90	3.06
Mistakes treated as learning opportunities	3.39	3.09	3.11
Professional contributions valued	3.14	2.96	3.21
Physicians are respectful	3.04	3.13	3.11
Staffing schedules are managed fairly	3.15	2.86	2.72
Comfortable asking questions	3.58	3.41	3.33
Satisfaction with schedule	2.96	2.68	2.67
Satisfaction with job	3.41	3.14	3.11

(Halfer & Graf, 2006)

The wide range of ages within nursing work groups can lead to intergenerational communication problems, including:

1. Individuals in one generation finding it easier to communicate with their own generational group than with someone of the same gender, education, region or class born into an earlier or later generation (Scollon & Scollon, 2001).
2. People finding themselves caught between goals, identities and ideologies of different generations (Scollon & Scollon, 2001).
3. Difficulty in intergenerational communication causing disruptions within organizational settings (Scollon & Scollon, 2001).

Nurses encounter conflict daily—it is the nature of the medical profession. Their identity is defined by their age, education and experience, along with their medical interpretation and personal understanding of their role as a nurse. Conflicts evolve as nurses attempt to control perceptions about the characteristics of their identity, group and culture. In the case of the nursing profession, members experience this conflict in their interpersonal, group and organizational relationships (Rahim & Bonoma, 1979; Cox, 2003) as viewed in Table 2.8.

Table 2.8

Nursing Conflict

Conflict	Explanation	Examples
Intrapersonal	According to Zey-Ferrell (1979) this form of conflict often exists in a cognitive and affective realm. Individuals may perceive that they are in conflict with others when in reality it is in their mind.	• Mis-assignment and goal incongruence • Frustration of experiences • Lacks expertise or aptitude • Lack of commitment • Inappropriate demands on self
Interpersonal	Frequently occurs between nursing personnel due to personal and professional differences. These conflicts are the most common and are known to directly affect the work satisfaction of the nurse.	• Educational background (RN-BSN vs. Diploma RN) • Age • Tenure and experience • Percent of like personnel (% of RNs) • Different career patterns • Jargon and semantic differences • Class differences • Gender or race differences • Value and focus • Relationship with physicians or other healthcare workers • Scarce resources - Assistive personnel - Equipment and supplies - Physician time and attention - Resources for patients - Higher wages - Shifts and better hours - Lower patient ratios - Best position (Kreps & Thornton, 1992)
Intra-group	Refers to disagreements or difference among the members of the group or its subgroups. Typically they are related to goals, functions and activities that the group participates within	• Leadership style • Task structure • Group composition • Groupthink • External threats and outcomes

Table 2.8, continued

Intergroup	This conflict refers to disagreements or differences between the members of two or more groups. Typical disagreements are over culture, authority, resources and representation with the organization.	• Difference of agreements - Authority - Territory - Resources • Area of expertise • Jargon and semantic differences • Relationship with physicians or other healthcare workers • Scarce resources - Assistive personnel - Equipment and supplies - Physician time and attention - Resources for patients - Work environment
Inter-organizational	The differences occur between the member of the group and the organization. They are considered employment level conflict; however, occasionally they may also be between facilities within the same organizations such as multi-facility medical centers. These conflicts can relate to practice, procedures and working environment.	• Work environment • Practices and procedures • Assistive personnel • Equipment and supplies • Patient load • Shifts and hours • Wages and benefits

(Derived from: Rahim & Bonoma, 1979; Cox, 2003; Kupperschmidt, 2000; Watson, 2002; Swearingen &Liberman, 2004)

Inter/intra group struggles can directly affect and define conflict within the nurse's practice and profession. This is a profession without the levels of seniority typically found in other fields. This absence of age hierarchy can lead to conflict based on assumptions and miscommunication stemming from generational diversity. In most professions, work places, seniority and age are associated with increased authority. In

nursing, however, the same job may be occupied by nurses of any age. Experience does not mean seniority.

Consequently, age and experience do not predict authority or deference. Nurses of different ages may have different levels of experience, they may have received their education from different schools in different eras—but they all have the same status on the job. At the nurses' station in the hospital, three nurses of equal status may include a 23-year old recent graduate, a 50-year old who graduated in the 1980s, and a 32-year old who recently acquired her nursing license after changing careers. Nursing articles and nursing websites discussion do not assume the other two will see the 50-year old as the leader, assuming instead that the three nurses will have conflict in their communication.

With generational differences present in the workplace, conflict is inevitable. So how do nurses handle conflict when it arises? Does age, experience or education make a difference in the conflict interaction? When conflict does occur, what facework is associated with group differences? Paramount to the conflict interaction is how diversity among nurses, their conflict behavior styles, and the face tactics used work together to manage and resolve the conflict in a way that potentially prevents harm to the practice of medicine. From these questions, I see an important and necessary need to study and understand how nurses characterize their styles, behaviors and face-saving tactics in conflict management when faced with a conflict within the profession.

Silence Kills

> *"To do what is right and good for someone requires that one has a reliable understanding of what is best for the person in moments of choice." (Skott, 2003, p.368)*

Since 2000, there have been a limited number of research studies regarding conflict in the healthcare arena. These studies have primarily concentrated on the implementation of conflict management strategies through the ranks rather than addressing the conflict styles of the professionals (Sportsman & Hamilton, 2007). The Joint Commission on the Accreditation of Health Care Organizations (JCAHO) has suggested that, due to poor communication, such conflicts can be a major contributor to sentinel events, as reported to the JCAHO (JCAHO, 2005). The publication, "Silence Kills: The Seven Crucial Conversations for Health Care" found that fewer than 10% of the 17,000 respondents said they would approach a fellow healthcare worker to address or discuss a behavior problem, a conflict or a concern. Relevant concerns from the study include: breaking rules, mistakes, failure to support, incompetency, lack of teamwork, lack of respect, and micromanagement through bullying, employing rank and the use of threats (Maxfield el al., 2005). This disturbing report further supports research from multiple investigators that nurses generally avoid conflict with a fellow healthcare worker (Baker, 1995; Cavanagh, 1991; Eason & Brown, 1999; Hightower, 1985; Marriner, 1982). Cavanagh (1991) further notes that those who ranked high on avoidance tend to work autonomously and not voice opinions. Relating this to both teamwork and patient care, decisions are made by default rather than by collaborated input, thus leading to problems in coordinating care. Relating this to the amount of intellectual decision the nurse must enact daily to perform his or her task in patient care and this finding of 'avoidance' may have life and death implications.

Corwin, in an old but still recognized study, attributes conflict among nurses in part to their role as 'hospital record-keeper'. In this role, staff nurses accept the role as

enforcer of the hospital rules and policies, many that may not seem relevant to the patient or the staff. In their position as floor enforcer of standards, nurses spend excessive time dealing with 'red-tape' instead of with patients. Eventually, this role becomes difficult to maintain as newer and younger nurses stop accepting responsibility for assigned task completion. However, hospitals continue to require loyalty and conformity to this procedure, resulting in conflict interaction between the staff members (Corwin, 1961). At the time of Corwin's research in 1961, neither the Thomas-Kilmann instrument nor the Blake Mouton model had been developed. Corwin related the conflict between nurses to cultural differences such as age, practice, education and experience. With the coming of new nursing research, as developed by nursing scholars and researchers in the field, the trend moved toward the development and definition of conflict as a listing of nursing actions rather than characteristics. Much of this was built upon the research of Peplau (1953) in her series of articles on nursing situational themes (later discussed in Chapter 4 – Results). Peplau pursues a path of three themes that cause conflict among nurses: power, safety (security), and stalemate (hopelessness). These themes, expanded and built upon fifty years later, were developed as a listing of features that trigger nursing conflicts:

1. Opposition or differences of opinion,
2. Priorities,
3. Roles,
4. Beliefs,
5. Perceptions
6. Practices,

7. Authority, and
8. Values during the conflict situations (Warner, 2001).

These attributes support the claim of Saulo (1987), as he investigated self-reported conflict style of nurses in the San Francisco Bay area, that conflict and management style may be more contextual in nature – as in the 'state' rather than the 'trait' (Sportsman & Hamilton, 2007). This concept relates back to the thought that the 'avoidance' conflict management style, earlier reported as the primary style, is maintained by the contextual state that the nurses work within, and has less to do with the individual personality trait of the nurses. This can be supported by the type of organizations they work in, which are typically patriarchal and do not allow most nurses to occupy powerful decision-making positions. It is this powerlessness that lead nurses to the avoidance management style of conflict (Valentine, 2001).

In sum nurses generally take a passive approach to conflict management (Valentine, 2001). Their management style in conflict is led by avoidance, closely followed by accommodation and compromise, and trailed by competition and collaboration (Eason & Brown, 1999; Valentine, 2001). However, to fully understand the conflict that nurses encounter today and on a daily basis, three antecedents surface as primary catalysts: lack of trust, lack of respect and poor communication (Warner, 2001; Almost, 2006). Coming from these antecedents are the conflict encounters most often revealed in nursing:

1. Relationship conflict – as in affective and emotional conflict that can be attributed to personality clashes, tension and animosity (Jehn, 1995).

2. Task conflict – as in differences in opinion and viewpoint regarding a task (Jehn & Mannix, 2001) and
3. Process conflict – as in how a task is completed, who does what and how things are delegated and performed (Jehn & Mannix, 2001).

Understanding the conflict arena for nurses, their management style, their state and traits, and their ability to work effectively within a conflictive situation can help address the earlier indicated 'scope of the problem,' which is: Why do nurses leave the profession? As stated previously, 30% of current nurses work outside of their profession. The ability to understand this industry dissatisfaction may rest decisively upon understanding the themes and issues of conflict within nurse-to-nurse interaction, and how face-saving tactics can play a role in the conflict resolution.

Research Questions

The objective of the research is twofold: first, to identify conflict themes related to floor/shift work among nurses; and second, to understand nurses' face tactics and how those tactics relate to conflict styles. Since the 'floor' nursing profession typically does not reflect a ration between power and seniority, the profession's unusual ability to provide a level playing field for nurses presents an interesting canvas to observe nursing conflict interaction. This rarity provides a research arena where conflict can be analyzed effectively in the profession with checked emphasis on issues of age, experience, knowledge and education levels.

Adams & Bond (2000) and Duschscher & Cowin (2004) found that nurses compete for power and control based upon the misunderstanding of other nurses – their characteristics, attributes, and processes. McNamara (2005) and Dunn-Crane, Gonzalez

& Stewart (1999) tell us that different groups can perceive their profession differently. Where one sees compassion and commitment, the other sees a means to create an avenue for service and personal growth. These understandings provide the foundation for a story-based, situational study of nurses in conflict with nurses. Therefore, a primary goal of this dissertation is to further explore the possible link between facework and conflict themes in the context of nursing conflict. Therefore:

RQ1: In the stories that nurses tell about conflict, what communication themes are discernible in their talk about nursing interactions?

A list of face defensive and restorative tactics (as displayed previously in Table 2.3) was derived from multiple published studies commonly used to protect or rebuild a relationship within a conflict event. From the nursing stories told:

RQ2: What communicative face tactics and strategies do nurses use when involved in a conflict interaction with another nurse?

A. In a defensive posture?

B. In a restorative posture?

Chapter Three: Methods

Overview

Max Weber called it *verstehen*—an immersive approach to understanding a culture. It's a process of viewing research through a naturalistic lens to capture not just data, but meaning. Weber's approach provided a comprehensive canvas on which to paint the philosophical, technical and methodological aspects of my study.

The narrative style of data collection seemed a natural choice, organically creating the classifications, categories and themes that would become the foundation of my research. The result is a naturalistic phenomenological-construct model that allowed me to research unexplored social-realities inside real-life experiences. By studying specific behaviors in authentic situations, I viewed participants as integral parts of their environment. The perspective broadened my view, permitting me to interpret a subject's actions in comparison with other individuals in very similar circumstances. This phenomenological research style helped me to understand and interpret the meaning of human experiences through specific behavior and situations.

I employed Glaser and Strauss' concept of grounded theory (GT) as I analyzed the data from this study of face-tactics and conflict interaction. Grounded theory, as maintained by Glaser & Strauss (1999), is an effective approach for analyzing the complexities of human interactions. In short, it is one of the best options for answering Glaser's deceptively simple question "What is going on here?" (Morse, 2001). Using grounded theory, categories and themes were systematically derived from the nurses' stories of conflict (Gubrium, 1988).

Over the past three decades, grounded theory has grown in status in the nursing profession (Hutchinson & Wilson, 2001), a field that has traditionally followed a quantitative approach to research. Nursing has embraced GT as a means of opening new avenues of social investigation. For nurses looking to understand phenomena within nursing concerns, GT has become an assessment guide that provides new approaches to evaluation and research. GT explores the meaning behind the action (Hutchinson & Wilson, 2001). "It is up to us [the researcher]," Goldman (1980) states, "to accept the challenge of strange and difficult ideas and to abandon the complacency of converting all that is novel into clichés of the familiar" (p. 14).

The Search for Themes

Themes were identified by seeking conflict between nurses through stories of interaction and categorizing the conflict interaction into descriptive themes. As the concept of themes is one of the most important concepts in qualitative research (DeSantis & Ugarriza, 2000), I sought a variety of theme definitions to better understand the nursing interview. My intent was to dig deep into the personal understanding of a nurse to nurse interaction, exploring how it affected them at the moment and examining its impact on future interactions. From my own investigation into themes, I discovered the following:

According to Morris Opler (1945), the "term 'theme' is used in a technical sense to denote a postulate or position declared or implied, and usually controlling behavior or stimulating activity, which is tacitly approved or openly promoted in a society" (p. 198). Spradley (1979) expands Opler's definition to include that "themes are larger units of thought. They consist of a number of symbols linked into a meaningful relationship" (p.

186-187) forming a cognitive principle (something that people believe and accept as true based upon the nature of their experience) (Spradley, 1979). Morse and Field (1995) conclude that "thematic analysis involves the search for and identification of common threads….that are usually abstract" (p. 139). Therefore, a theme is "an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations. As such, a theme captures and unifies the nature or basis of the experience into a meaningful whole" (DeSantis & Ugarriza, 2000, p. 362). The themes have form and pattern, functioning to unify thought, acting as an underlying factor or common denominator in explaining and giving meaning to an experience (DeSantis & Ugarriza, 2000).

The Data

Data for this study came from: the stories and actions of nurses; information acquired through interviews; observation; and a review of professional nursing literature and blogs. The use of these three approaches—observation, study of literature and interviews—allowed me to triangulate findings resulting in a rich meaningful explanation of social interactions and context within the nursing profession.

The Observations

Nurses encounter interpersonal conflict daily, as in the patient-service situations explored at the beginning of this paper. Personal and field observations bring meaning to a study but can be difficult to acquire. HIPPA restricts access to clinical and acute areas, creating a stumbling block for any researcher. However, I was able to collect the additional data through observations made during the personal interviews with the nurses. The interviews provided me with the opportunity for casual conversation and visitation and I was able to observe the subjects before and after the official recorded interview.

This resulted in the collection of data that might have been difficult to acquire when the recording device was turned on.

During these conversations and observations, I witnessed both non-verbal and verbal interaction from the nurses. Through this process, I was able to examine and refine my ultimate approach by viewing how the nurses communicate and express thoughts and concerns about their job in a more relaxed environment. I discovered that nurses run the gamut on personality traits and characteristics – open to reserved, extravert to introvert. This observation was both interesting and encouraging. I soon realized I was engaged with a diverse group of professionals. Most important to my research was the discovery that interpersonal interactions between nurses had a level of deviation from the traditional concept of employee interaction. My lead question in the interview dealt with employee interaction and I began rethinking my method of gaining access to nursing conflict stories. From these pre-interview conversations and visitations, I detected that nurses interact interpersonally on an informational basis. If I proceeded with my original plan to inquire about general nursing interactions, I would have been inundated with generalized stories of nurses' inquiries – the whereabouts of the support staff, the doctor or a particular piece of equipment or medication. This, I realized, was not going to bring the stories of conflict interaction needed to address conflict themes and face tactics. It was from observation and casual conversation that I encountered the nursing concept of 'good nurse' versus 'bad nurse'. Each of the nurses viewed themself as a "good" nurse and, subsequently, they consider the opposite of the good attributes to be that of a "bad" or "problem" nurse. These became my keywords to connect the concept of nursing interaction to that of conflict themes and face tactics. This idea of a good nurse

compared to a bad or problem nurse is more fully examined and explained in Chapter Four's subsection – Understanding nursing. Although my original plan of observing at actual nursing locations was impossible due to HIPPA regulations, I believe the experience of pre-interview casual conversation and observation provided an important insight that enhanced the richness of the data and the results it provided.

The Professional Literature

> *"We look for evidence of culture at those minute points of contact between new thing and old habits" (Trachtenberg, 1986, p. xiii).*

Nurses Week, ANA Online, Hospitalconnect, and other professional publications have some surprising headlines: "Do Nurses Really Eat their Young?" and "Why Emotions Matter: Age, Agitation and Burnout in RNs". Various nursing blogs, such as *AllNurses.com,* provide an additional forum for individual nurses to express their opinions and frustrations: "Boomers are so emotionally drained by the torrent of new nurses coming and going that they are barely able to establish a connection with them. They realize this instability has made them resistant to nurturing these new recruits in the effort to improve an environment that is in desperate need of such support." (Molly, personal blog, Jan. 12, 2002.)

Professional nursing-literature and blogs are satiated with examples of conflict in nursing. Industry analysts and insiders have shared stories and advice in places like Allnurses.com, American Nurses Association publications and in the Department of Veterans Affairs-ADR Newsletter. As sources of data, they offer explanation and insight into conflicts in American nursing.

I accessed AllNurses.com and NursingLink.com portals to nursing blogs and forums. These internet blogs provided access to several thousand nurses nationwide that participate (some daily) in various blog topics. These nurses vary in age, location and professional status, bringing a diverse perspective to the data. Using the blogs and forums, I was able to verify points and issues told by my participants in the interviews. For example, nine months ago a blog was launched in response to the article "Do nurses really eat their young?" While the blog addressed the article, it opened a channel for interactive commentary about whether older nurses treat new graduates with disdain. By participating in the forum, I was able to redirect the blog with the questions "Do you feel that you have to defend yourself to the older nurse? Do you see the need to save face with them…and do you do it?" Responses to the inquiry continued to appear in the blog thread providing me greater insight into the nursing mindset. Among them were comments from young graduate-nurses expressing frustration and hostility. One read, "Yes, I have to defend myself…otherwise they will not respect me." Another, "No, there is no reason to try to save face with them. They wouldn't care anyhow." These are examples of how nursing blogs provided me with a wealth of personal responses. Then, when I heard the phrase "nurses eat their young" in my interviews, I was able to expand the statement with additional questions that developed further insights into nursing conflict, an insight that I would not have had if not from my experience with online nursing blogs.

Nursing is diverse and extensive with a multitude of nursing journals on topics like: leadership and management (JONA – Journal of Nurse Administration); current research (JNR – Journal of Nursing Research); specialty practice (AORN – Association

of periOperative Registered Nurses); general nursing (JAN – Journal of Advanced Nursing); treatment (HNP – Holistic Nursing Practice); and nursing groups (Journal of Men in Nursing, Nurse Educators, and Journal of Christian nurses). Lippincott and Wiley together publishes ninety-nine nursing journals. My task was to seek the nursing journals related to face and conflict. From a preliminary search, face was not a commonly identified topic—nursing conflict and conflict style, however, is often addressed. As is evidence in selected citations throughout this proposal, professional nursing literature attempts to systematically address the contemporary issue of nursing conflict. I found this helpful and realized that many of the conflict themes I identified were overlooked within the literature. The issue of face and facework within nursing articles is, on the whole, non-existent. Though it would have been advantageous to have literature to review on the subject matter within the profession, not having it did not deter or alter my study. What the void in the literature did accomplish was to provide a new avenue for research within the profession.

The Interview Data Collection

Selection criteria.

The goal of the interview was to collect stories. These stories provided insights into nursing related conflict and the subsequent use of facework. Nursing employees, specifically shift nurses, were the primary participants of this study. Their stories provided the bulk of the research data. To be selected for inclusion, each nurse was required to fall into one of five age (generational) categories, as provided by Gravett and Throckmorton (2007) in Appendix B. All of the nurses would currently be employed within a healthcare organization as a subordinate, superior (supervisor) or contract

employee. The nurses were to be shift nurses, referring to nurses that work directly with patients and do not include administrative/executive nurses that do not actively participate in floor/shift activities. As a shift nurse, participants report to a shift/floor charge (head) nurse, department director or healthcare administrator. Organizations they worked for were to be healthcare facilities providing health-related services to the general public, and the participants were primarily, but not exclusively, employed in hospital floor-nursing. All of the healthcare organizations in the study were located in south Central Texas. The facilities ranged from medium (150+ beds) to large (500+ beds) and represented both non-profit and profit, adult and pediatric care, acute and emergency care, rehabilitation and skilled nursing care (non-rehabilitative). Every hospital group or corporation in the south Central Texas region was represented in the study with the exception of a local heart specialty hospital.

The study group consisted of participants licensed by a state board of nursing with some possessing additional certifications within the profession. Nurses included in the study were primarily board licensed Registered Nurses (RN). A Registered nurse refers to a nurse that has completed at least an associate's degree in nursing (ADN) or a Bachelor of Science degree in nursing (BSN), and has also successfully passed the certification exam (NCLEX-RN). These nurses constitute the largest block in the health care field. There are approximately 2.5 million registered nurses and 59% are employed in hospital settings. RNs are trained in theoretical and clinical foundations to assess patients, plan treatment and intervene with patient care. Their distinctive scope of practice allows them to practice independently, though they traditionally work in partnership with other health care members. For this study, License Vocational Nurses

(LVN) and License Practical Nurses (LPN) certifications were also included, but on a minimal basis. Certifications, as shown in Appendix E, were defined by credentials awarded or earned through academic, state or nursing organizations. These credentials included a broad listing of specializations, practice areas and academic degrees. Of the credentials listed, many were restricted to only registered nurses due to the requirement of higher education (BSN). The appendix, however, lists all possible nursing credentials available to any individual involved with patient care.

The selection process.

The participants were selected via a convenience sampling with a goal of data saturation from the stories of the qualified participants from the nursing profession in addition to the nurses used in the pilot study. The number of participants (24) was a subjective figure that allowed for diversity of narratives while allowing for the possibility of saturation within the dataset. It was my intention to continue until I find 50-75 rich nursing narratives (94 was the actual number of stories recorded). The number of interviewees could have been adjusted upward if the resulting narratives were less productive and failed to provide sufficient detail or information.

Potential participants were solicited through the popular website "Craigslist." The website serves as a solicitation/sales medium with listings divided by categories. A listing was placed in the categories of 'healthcare' and 'volunteer'. It read: 'Seeking RNs for a compensated research opportunity at the University of Texas'. The advertisement provided the research description, time required, compensation information, the place of research and the nursing qualification requirements. Applicants were encouraged to complete an online pre-qualification survey (via SurveyMonkey) as displayed in

Appendix F, allowing me to review their qualifications and determine each participant's appropriateness for the study.

A second method of solicitation was used to solicit nurses in local hospital's nursing stations and local uniform shops by posting an advertisement for research that targeted registered nurses. The advertisement listed the qualification of participation and offered a gift card in return for participating in a UT research study (see Appendix G). Potential applicants were encouraged to complete the same online survey as listed above. Both forms of solicitation listed the research as taking place at a University of Texas lab, classroom, or a location convenient to the participant, where a 90 minute face-to-face interview would take place.

From the responses to the survey questions (Appendix F), I was able to evaluate the potential participants and invite them to set up an appointment for the face-to-face interview via an online scheduler. After the participants created the appointment date and time, I was notified via email by the online scheduler and an appointment listing was created concurrently by the same service.

The participants were then emailed instructions regarding the interview and told to complete the Thomas Kilmann Conflict Mode Instrument (TKI) prior to our face-to-face meeting. To avoid any leading of the participants in the actual face-to-face interview, these TKI scores were not disclosed to the participants. All but two of the participants completed the instrument prior to the actual interview via an online link to the CPP, Inc. website. CPP, Inc. (formerly known as Consulting Psychologists Press), a fifty-year old assessment company, was chosen as the vehicle for the assessment due to CPP's reputation in the academic and business sector as a leader in employee assessment.

CPP, Inc. also is the legal possessor/vendor to several assessment products including Myers-Briggs, TKI, FIRO, and the Strong Interest Inventory, supporting CPP's reputation as a quality assessment interpreter and provider. The Thomas-Kilmann instrument is a recognized five-style model mapping of the interplay of task vs. relationship. The assessment uses a framework commonly attributed and credited to Blake and Mouton (1964), mapping responses to conflict according to the interaction of a horizontal and vertical axis. One axis is for assertiveness, focusing on one's own agenda; the other is for cooperativeness with a focus on the relationship. The assessment consisted of 30 pairs of forced-choice statements requiring the respondent to identify the behavior within a conflict situation by choosing the characteristic that best represents the response. The data realized from the TKI assessment was imported into Microsoft Excel creating a spreadsheet of demographics and results as shown in Appendix C. From this data, a comparison was made to the self-reported conflict characteristics of each participant (see Appendix H for a listing of self-report traits) and to act as a further descriptor of each nurse.

The last act before the actual face-to-face meeting was to verify the participants' nursing license through the Texas Board of Nursing (https://www.bon.state.tx.us/olv/verification.html). This website provides a list of the nurse's name, license (RN or LVN/LPN), initial Texas licensure date, license status, and current disciplinary action if applicable. All the participants met the credentialing verification and therefore remained in the pool.

The participants.

The participant pool selected was a diverse collection of nurses from all age groups, and educational backgrounds, with various nursing duties ranging from hospital to corporate to skill nursing, and tenure within their current employment. It would not be possible to describe an average nurse in the pool as the cross-section was diverse in all categories. In summarized terms, 24 participants were interviewed representing age ranges from the mid-20s to near 60s with 13.6% being male and 86.4% female (a breakdown that mirrors the State of Texas Health Services Center statistics for nursing – see Chapter Eight- Limitations). Twenty-four was the final number of participants as my intent was not the number of participants, but rather the number of conflict stories. From these 24 participants a collection of 94 conflict stories were recorded. Upon completion of the twenty fourth participant I realized a saturation of the data as conflict themes and face tactics begin repeating. At this point I elected to not contact or interview additional participants.

Gender differences were not a focus of the study but the breakdown of age groups is relevant to the findings as age difference has been mentioned in the professional literature as a catalyst for conflict. By category, the study was comprised of 25% (20-29), 37.5% (30-39), 12.5% (40-49), and 25% (50-59). The groupings loosely correspond to the years liberally designated in popular literature as Millennial, Generation X, Boomers and Veterans.

In education, the study includes 4% diploma nurse or some college, 21% with associate (ADN) degrees, 41% with bachelor's (BSN) degrees, 17% with bachelors and some graduate coursework, 17% with master's (MSN) degrees and terminal degrees of

NP (Nurse Practitioner, Doctors of Nursing as a practical degree, or PhD as a research degree). To avoid focus contamination, ethnicity and national-origin—while relevant to nursing research—were not focal points of this study, and non-citizens of the United States were excluded from consideration. The ethnic mix of the participants was 75% Caucasian (European-Americans), 12.5% Hispanic and 12.5% Asian. There were no Blacks (African-American nurses or African international nurses, such as Nigerians) in the study as the one black nurse that responded did not elect to advance to the interview stage – a limitation that is further elaborated in Chapter Eight – Limitations. From my experience with the profession, I have observed that salary can also create a catalyst for conflict as nurses are very aware of the pay schedule, with an older more experienced nurse making similar wages to a young, new and inexperienced nurse. For this reason, I included a collection of wage data in the participant's preliminary questionnaire. The summary of wage information is as follows:

1. Under $25,000 – 4.8%
2. $25,000 to $34,000 – 14.2%
3. $35,000 to $44,000 – 19.0%
4. $45,000 to $59,000 – 23.8%
5. $60,000 to $74,000 – 28.6%
6. $75,000 or more – 4.8%
7. Other amount - $4.8%

Though the breakdown reflects highly paid individuals, several of the nurses were discovered to be working more than one job to achieve the pay that they reported. This is due to the structure of the work shifts that nurses practiced within: three, twelve hour

shifts constituting a full week of work, thus allowing a second job in the remaining four days of the week. The complete demographic information of the participants is displayed in Appendix C, including the participant's TKI profile style score that was computed by CPP, Inc.

The Interview Process.

In the interview, I adopted a peripheral investigative-role and maintained a level of distance with the participants so they would view me solely as a social and academic researcher with a certain amount of medical/nursing knowledge due to my wife's practicing within the profession that I revealed early in the interview. Toward that end, I purposefully avoided displaying any personal knowledge of personality conflicts, disputes related to organizational management or structure, or any other issues that could bias my questioning.

Semi-structured, in-depth interviews using open ended questions (see Appendix H) were used to solicit responses. The purpose of the interview was to collect a group of narratives regarding nursing conflict that occurs in the shift/floor setting. In talking freely and conversationally, participants were able to develop their own "lived-narratives" which allowed me to probe the conflict event and explore how face tactics were used.

The interview introduction.

At the interview session, prior to being interviewed, the participants were presented with the required Institutional Review Board consent form (see Appendix J) and received verbal information about the content and purpose of the research study. It was my intent to collect conflict stories of nursing; however, I did not want to prime the nurses by disclosing the intention. Rather, I asked the participants to describe the

characteristics of a good nurse and a bad or problem nurse. It was this discussion that provided the entry to explore the conflict interactions between nurses. Participants then learned their interviews were being audio-recorded and subsequently transcribed by an outside, professional transcription-service. Participants were additionally notified of the confidentiality of their comments and that the recordings would be preserved for future research by the interviewer or the University of Texas at Austin.

After reading the consent form, participants in the study were asked to update their demographic and educational information (see Appendix F). This is for coding purposes, providing the data necessary to categorize participants by licensing/credentials, gender and age group. Coding would assist in creating visual representations of the demographics. The participants were provided a list of nursing credentials (see Appendix E) to indicate their license and certification (answering question 9, Appendix F). This listing was not provided in the online survey due to its length and the length restriction of the survey. The nursing license, previously confirmed during the application process, did not need to be reviewed again. The participant then proceeded to the actual interview.

The interview.

The participants were asked to address the question (see Appendix H) of "What makes a good nurse?" and "What makes a bad or problem nurse?" From the response the participants were asked to think about past conflict interactions recalling a personal situation in which they interacted with another nurse on the floor or in the department. The "good nurse, bad nurse" question helped the participant to remember stories of conflict. A participant who could not identify a personal experience was asked to relate a conflict of another nurse known to them. The nurses then detailed the experience,

recounting the actions of all parties and shared the thoughts and feelings about the incident including any emotional response or physical reaction. To my surprise the nurses provided multiple stories on professional conflict, some recalling memories back to their early years in nursing. It was these early stories that were often infused with issues of ethics and procedural differences among the nurses. At the conclusion of all the interviews, I was pleased that my dataset of nurses created an authentic and unique dataset of 94 solid stories of nursing conflict interaction.

At the completion of the interview, I showed the participants the listing of conflict styles called "How you act" (see Appendix H). I asked each participant to list in order, greatest to least great, the top-three styles of handling conflict. I considered this the participants' self-report on their personal conflict management style. The information collected from this self-report was incorporated and viewed with the data from the Thomas Kilmann instrument the participants had taken earlier which is displayed in the demographic spreadsheet (see Appendix C).

After the interview, each participant was asked about the availability for follow-up interviews (if needed) in order to clarify answers or ask additional questions that may arise during other interviews. There were only two situations where a participant was re-contacted to clarify remarks that could not be deciphered from the audio recording. Any additional comments or requests made by the participants, including copies of the study's final results, were noted. Upon departure, the participants were given the gift card.

It was my role to prod the participants to reveal how and why they did or did not attempt to save, defend or restore face (as displayed in the interview questions listed in Appendix H) during and after the dispute. As I listened to the participants, I compared

the participants' response and data to the communicative practices of face defense and restoration (displayed in Table 2.3 and Appendix O). This analysis became the primary means of identifying different face tactics and strategies used by nurses when engaged in a nurse to nurse conflict interaction. From this analysis, research question 2 was answered.

In addition to recording the interview, I took notes during the interview referring to the audio recorder's counter to note any unusual reactions during the interview. These reactions were noted in a field journal using time-counter entries to chart phenomenological responses. Notable responses included highly valued statements, changes in voice pitch and tone, or emotional or physical reactions occurring during a specific answer. Notes from this journal were then reviewed with the completed interview transcription.

The interview data and transcription.

The interviews were accomplished over a one month period with each interview lasting approximately 90 to 120 minutes. From the 94 stories recorded, a total of 840 transcribed pages of double-spaced text were created by *LK's Transcription Service*, a transcriptionist service located in Austin, Texas. Selection of this firm was based on the service's reputation for professionalism and accuracy in transcription. The transcriptionist has been a transcriber for forty years working extensively with dissertation and research projects for various University of Texas graduate students and departments. By double checking the transcribed text to the actual recording, I found the service to be accurate and reliable. I furthered listened to the audio recording and reviewed the transcripts looking for any issues missed in the transcription process. These issues would include

false starts, repetitions and hesitations in the participant's responses. As transcription services seldom include such notes in the transcripts, my review allowed me to add marks and comments from my field notes once the data had been imported into the software.

Nursing blogs and professional literature.

From my interviews with the nurse participants, I recognized that nurses tend to communicate and provide information differently depending upon the setting and the individual(s) within the interaction. This was both concerning and interesting to me as a researcher. I had found nothing in the professional literature or blogs to shed light on many of the issues I was exploring, except for generational differences in the nursing workforce (see Molly, 2002; Swearingen & Liberman, 2004; Smith-Trudeau, 2001; Blythe et al., 2008). Most of the nursing blogs addressed a generational communication style that mirrors the public sector. The professional literature provided the same but with additional data and support from the field. However, as I was conducting my 24 interviews (21 interviews plus 3 pilot interviews) I discovered a hesitation that would surface in the nurses as they related their stories of conflict. My first thought was the public account versus private account issue that I later address in the trustworthiness section. Another issue could be the nurses' concern for HIPPA (Health Insurance Portability and Accountability Act of 1996) or PSQIA (Patient Safety and Quality Improvement Act of 2005) violations. But after quizzing the nurses about their hesitation, I learned that it was their idiolect, their 'inside' language — specifically, their own professional language that they feared was either atypical and disconcerting or even judicious and prejudiced. At this juncture, I realized the benefits of nursing blogs and the professional literature.

It was the nursing blogs and the professional literature that provided me with the avenue to understand stories, themes and tales of conflict. In these blogs and the blogs' stories I could search, inquire and question words, phrases, decisions and actions. One nursing blog stated it most clearly: "it occurred to me that nursing has its own language.....a special jargon which can be used by anyone, but only truly understood by insiders [nurses]". Another nursing blog gives an excellent example of this 'inside' language with a word that I heard multiple times during the interview.

> "One of my personal favorite words is 'perseverate', which I'm not even sure IS a word. I've always suspected it was a made-up combination of 'persevere' and another word---'irritate', maybe?—that's used so often that healthcare professionals have accepted it as part of the lexicon. It's certainly used often enough in residents' progress notes when nurses are particularly exasperated with hearing the same complaint over and over, e.g.,'Hailey has come to the nurses' station 12 different x's this shift, perseverating on the idea that [her] roommate is stealing her underwear even with staff reassurances to the contrary'" (VivaLasViejas, 2011).

Various words and acronyms surfaced before and during the interview. It was this element of the nurses' language and communication that led me to turn to the nursing blogs. One of the participants used the phrase, "What is an old, decompensating nurse supposed to do?" (Mary). Not wanting to question the meaning of the word 'decompensating', fearful that it would take away from the flow of her story, I found myself later searching blogs and literature to find its meaning. Discovering that decompensate is used by nurses to refer to 'challenged' or 'vague' conditions, I gained a

better understanding of this middle-aged nurse who works multiple jobs to survive. In some instances, this new language gave me an entirely new picture of the nurses and how they saw their profession, their colleagues, their patients and themselves.

The nursing blogs and professional literature also introduced to me a new language of acronyms. From my experience with nursing, I knew the most common acronyms: PRN, bid, ICU and PICU. What I found interesting, and what furthered my understanding of this unique nursing-language, were the new and specialized acronyms:

ART = Assumed Room Temperature – as in: deceased. "She's art!"

DRT = Dead Right There – as in: already deceased. "He was 'dirt' when I came in!"

HDJ = He's DEAD, Jim! – as in: brain dead and nothing can be done.

ETOH (or "Highly ETOH") – as in: drunk. "She's ETOH" (telling the other nurse about the drunken college student in the ER in front of her friends).

WTF = What's this for – as in why was this prescribed. This is not the traditional WTF that most people think it stands for; however, I had one nurse that said she thought the acronyms' two meanings were probably interchangeable.

As I completed the first few interviews, I found myself understanding the terminology of the nurses. When I used some of the same phrases, such as, "so this was a 'he's dead Jim' situation, right?" the nurses opened up to a greater extent and seemed more relaxed.

As a means of triangulation, the blogs and professional literature served two purposes. First, they verified certain elements of the nurses' stories. Charlotte, one of the first nurses interviewed, told the story of an infant who died in the ER due to the slow reaction of the attending physician. Charlotte tells that the 'blue baby' was not going to

survive too much longer without surgery. I wondered about Charlotte's claim and if she was defending any participant(s) in her story. Academic journals and medical encyclopedias could have provided me with the answer to my question about blue babies; however, the blogs were of greater value. Reading the blogs after my interview with Charlotte not only verified her statement but also gave me a new understanding of Charlotte's comment and perspective. Below is the blog entry that led me to better understand Charlotte's comment.

> "My biggest fear was giving the baby a pneumo. But that is fixable. The doc handed me the limp *blue baby* and I immediately began PPV. I really thought they had handed me a dead baby. I remember thinking to myself, 'They expect *me* to fix *this*!' Then I thought, 'Even if the baby is dead, you have to go through the motions'" (33-weeker, 2007).

The second benefit the blogs and the professional literature provided was to clarify details and create a more open, narrative interview. Many of the nurses entered the interview apprehensive and timid. This was probably due to encountering an unfamiliar situation. However, by reviewing blogs and professional literature, I was able to conduct the interview using nursing language. In addition, I could cite names of publications that they read on a weekly basis. Although I could not fully communicate on their medical level, the blogs and literature provided me the verbal avenue to extend questions, elaborate and ask for more detail on answers, and to question certain claims that were made. At the entrance to this study, I considered nursing blogs and professional literature to be minimal contributors to the research process. By the conclusion, I realized that both were significant and valuable to the findings of the study.

Coding and Analysis.

Using the Strauss and Corbin (1998) method of comparative interpretation of qualitative analysis, the transcribed interviews were coded into identifying categories, classifications and the following themes (Glaser & Strauss, 1999): conflict themes; face-saving tactics; and conflict-behavioral styles (using both the participant's self-report in Appendix H and the results of the TKI assessment). The coding process proceeded through four phases: 1) comparing categories to other categories, 2) categorizing and comparing incidents to specific categories, 3) identifying theory, and 4) writing theory (Glaser & Strauss, 1999).

To accomplish the coding and analysis task, I used the most recent qualitative-coding software, NVivo8 from QSR International. I used the software for the following:

- Basic qualitative coding (identifying themes and categories)
- Axial coding (a second-pass process to relate categories and concepts to each other)
- Vista coding (a QSR term referring to a platform view of data)
- Comparison (forming relationships between the categories and concepts)
- Report generation.

An integral component of the software was the use of nodes in coding. A node, defined as a structure that contains a value, condition or attribute, represents a separate data base. Therefore, each node was considered a *free node*, having its own definition of characteristics with no presumption of relationships or connections. In addition, nodes became part of a larger group, becoming what is referred to as a *tree node*. The tree node is a data structure that imitates a hierarchy or branching structure within the data, linking

various nodes together by connecting points to subcategories. An added benefit of working with tree nodes was the ability to create order in randomness, bringing about conceptual clarity and identifying themes and patterns (Bazeley, 2007). Following the QSR concept of vista coding, whole sections were then double-coded to provide additional verification of the previously coded context or statement. This confirmed the accuracy of the context of the statement and validated the themes extracted. Once the nodes are identified, the next process was to develop pattern coding.

The specific coding plan designed for this research (for conflict themes, face tactics and conflict interaction) was to first create the free-nodes stage, sorting out possible conflict theme characteristics and attributes like anger, frustration, position, ethics, work concepts and hours, etc… Nodes were then moved into a category for further development. The second stage, branching, organized the free nodes into tree nodes (specific titled conflict themes, etc…). The third stage identified any overarching concerns such as plans for the future, life values or ideas of employment. The final stage involved the connection that extends from pattern coding, a process defined by connecting concepts that come from two of more of the tree nodes or overarching concepts. This joining created the general types of explanations: the theme titles and descriptions. From the model, NVivo constructed a model for theory extension by piecing together and viewing the nodes as a whole, telling the story of the interaction, themes, statements and insights. This practice, considered 'modeling a case', shows how the nodes all come together to tell a story, forming the information and insights that constructed the results and discussion section of the research (Bazeley, 2007). It was from this 'modeling a case' that the interviews were imported into the software, reviewed

for relevance to conflict, and categorized into conflict themes. The listed themes were then supported by the evidence of the conflict interviews displayed in the results section of this paper. From this process, I was able to answer research question #1 regarding communication conflict themes within nursing conflict interaction.

NVivo was used less vigorously for the face-saving tactics than for the conflict themes identification. The face-saving tactic identification was conducted through a more hands-on process by extracting dialogue and comments from the nursing interaction and then matching current and new face-saving tactics to each statement or response. This time-consuming method helped to identify many new tactics as well as face-saving tactics previously explained in scholarly works. The comments that were coded with face-saving tactics were placed into two categories. The first category similarly matched the conflict themes earlier discovered; however, the second category required a higher degree of subjective analysis. This process required the matching of each face tactic to one of the five conflict styles defined by Blake and Mouton (1964), Thomas and Kilmann (1978), and Rahim and Bonoma (1979), which was further supported by the Wharton-TKI grid approach as stated by Shell (2001). Each of these five conflict styles was placed under the facework of defending face or restoring face. Then, within the two facework (defending and restoring), each face tactic was classified under the corresponding conflict style to allow for exploration of possible patterns and trends of the face tactics within the conflict interaction. From these categories, the face-saving tactics would provide an insight into which tactics could be seen in which conflict theme, a finding explored further in the discussion section of this document.

Trustworthiness

Trustworthiness—it is the end result of pursuing essential, unbiased quality in scholarly research. The trust element relies on several criteria: credibility (value); neutrality (confirmability); consistency; and applicability (or transferability). These factors affirm the trustworthiness of a given study (Lincoln & Guba, 1985). Having identified areas of potential concern, the following steps were taken to avoid potential data-corruption:

- ***Public account versus private account*** – participants may provide one account in a public setting and a different account in a private setting. Since contradictory accounts can arise in nursing, as in other professions, I proceeded with one-on-one interviews rather than conducting focus groups. This decision is supported by (and nursing literature affirms) various deficiencies from using focus groups. I consider this statement significant in explaining my action since the focus group interview is an excellent way of supporting the trustworthiness of individual interviews.

  Nurses, in my review of popular nursing literature and blogs, tend to provide information differently in a public setting than they do in a private setting. The question is, why is it different? To find the answer, I looked at how nursing differs from other professions. What I discovered from reviewing nursing blogs is that nurses consider themselves to have their own communication style. According to one nurse's blog: "it occurred to me that nursing has its own language.....a special jargon which can be used by anyone, but only truly understood by insiders". Other blogs indicate that continual education and professional credentials (see Appendix E – Nursing related credentials) create a

sense of 'specialized status' within the profession. These two items were a concern at the onset of the interviews. But as stated in the previous section regarding professional literature and blogs, I discovered that by recognizing and incorporating nursing language and acronyms into the discussion, I could enhance the interview process.

I discovered from my participants and from nursing blogs that in public settings, nurses are often hesitant to provide views on health issues—including protocol, procedures, policy (personally and organizationally) and personal practice preferences—for fear that it might conflict with the viewpoints or methods of those with a different nursing or educational background. Even minor differences can be threatening if they conflict with the views of an employer or supervisor. Because of differences in training and experience, "group-think" is minimal in the nursing environment. Personal inquiry and observations indicate that nurses with contradictory views tend to remain quiet. Part of the behavior stems from the profession's heavy focus on regulation. Nurses feel managed and "restrained" by HIPAA (Health Insurance Portability and Accountability Act of 1996), PSQIA (Patient Safety and Quality Improvement Act of 2005) and their employers, even in instances where they can claim "safe harbor" in expressing their views. Nurses, it seems, feel the weight of an invisible regulatory-hand and muzzle themselves to avoid potential repercussions, organizationally and legally.

This tendency can make data obtained in a public setting with other nurses less reliable than data derived in a private, one-on-one setting. While I did not intend to use public interview sessions to obtain information, no contradictory

public/private accounts came to my attention. If it had occurred, I would have re-asked the question in a different style or blended the inquiry into a line of questioning that better ascertained the private viewpoint.

- ***Reflexivity*** – in an effort to ensure good, qualitative research, the interviewer must remain aware of himself in the context of the situation and be cognizant of how he helps or hurts the process of constructing the narrative (Bloor & Wood, 2006; Grbich, 2004). While reflexivity is useful to the researcher, it can also produce errors if the researcher's contribution reflects any bias or preconception. Still, a knowledge of the nursing industry is beneficial to a successful research study of the profession. The industry has many unique facets to draw direct comparisons with other professions. Diversity in education and certifications, industry specific language, federal regulation and distinct employer policies and protocols contribute to the profession's uniqueness, differentiate nursing from the perceived "typical" American industry. I am familiar with the unique facets of nursing by virtue of my proximity to the profession—in a sense, my research begins with 30 years of observational preparation. My intimacy with the profession (see section - Limitations, and Appendix D - Confessions of the Researcher) instilled certain biases, but simultaneously provided an insight into the unique workings of the profession. Bias, while troublesome, can be overcome. According to Denzin (1978), rigorous efforts to focus on quality and trustworthiness can effectively reduce or eliminate a researcher's biases. While no one can totally eliminate this factor, by being aware of the pitfalls and danger signs the researcher can prevent it from corrupting the study. Reflexivity, it appears, is a double-edged sword: the

researcher's knowledge of the subject allows him to dig deeper; but preconceived notions can result in the wrong line of questioning and inaccurate interpretations (Kirk & Miller, 1986).

Undoubtedly research can be tainted by subjective positioning, as defined by Goodall (2000), when personal experience guides the direction of the study; however, awareness of subjectivity is critical to the study's reflexivity. The key was staying aware of my perspective: I am not a nurse myself, with attitudes and values from that work experience; I am a researcher honestly seeking stories and tales from nurses. With this perspective I was able to maintain my observer's focus by continually filtering my personal thoughts, opinions, values and assumptions as I studied my subject's stories of conflict.

- ***Factual narratives*** –From personal researching into professional literature and nursing blogs, it appeared that the nurses did not characteristically inflate, embellish or exaggerate the stories. Perhaps the nurses' precise explanations stemmed from their professional training—habits which direct them to provide only facts when communicating health situations to a doctor, nurse or family member. 'Fact stating' as a job requirement evolved from the nursing code of ethics—this job plank is well known in the nursing profession and has been repeated to me by several individual nurses. Violators risk losing their license if found to have engaged in unprofessional conduct. Additionally, misleading, deceptive or exaggerated communication can result in nursing board discipline. The Texas Administrative code, as adopted by the Texas Board of Nursing Licensure, prohibits "providing information which was false, deceptive, or

misleading in connection with the practice of nursing" – Texas Occ. Code Ann §217.12 – (6) (h) (Texas Admin. Code, 2004). Exaggeration, therefore, was a serious offense that could create serious consequences for the nurse. The stories told in the study appeared to be consistent and unexaggerated; although it would be impossible to be completely certain of the content of the stories.

- ***Indexing (coding)*** – a process where the researcher, working in grounded theory affixes biased meanings to words or categories in the coding process; or attempts to place data in the wrong categories. Indexing (or coding) may be better controlled through the use of professional coding software. While an experienced coder can effectively color-code manually, coding software, such as NVivo, provided tools to incorporate pattern coding and overarching views through vista coding, essentially alleviating indexing bias (see section – Coding and Analysis for further detailed information). In addition to traditional coding, 'modeling of case' was a fail-safe mechanism incorporated into NVivo to ensure a succinct and plausible story, rather than a fractured account.
- ***Key informants*** – describes a scenario where the researcher may select the wrong individuals (biased or misinformed) and place a disproportionate weight on their testimony, affecting the outcome of the research. Assessing the quality of the key informants rests largely on the thorough examination of the preliminary, qualifying emails including verification of license (see section – Interviews). This stage was followed by the face to face interview.

Triangulation

The study strived to achieve internal validation through extensive literature review and rigorous, triangulated research measures. Although the in-depth interview was the study's predominant technique, triangulation supported the findings by incorporating professional nursing literature and nursing blogs along with observational notes. Though direct participant observation and interaction on the actual 'hospital floor' would have provided a day-to-day reality advantageous to qualitative research (Scollon & Scollon, 2001), those measures were denied by the participating organizations. Therefore, observation and field notes (as noted in section – Observations) substituted for 'hospital floor' and 'on the job' observations.

Scollon & Scollon (2001) provide a striking example that supports the need for triangulation: "Often a member of a group will say something like, 'We always do X; but of course, I'm rather different and don't do that.' It is very common for members of groups to state both a general, normative principle of behavior and then to also state an individual departure from that behavior" (p. 19-20). In anticipation of these occurrences, I triangulated across interviews by using cross-examinations (a form of confirmability). As the research was conducted by a single researcher, I did not have the ability to maintain peer examination, peer audits and comparison interviews. To mitigate this deficiency, I structured each subsequent interview with responses from the previous interview to create an additional level of verification. This method produced interviews that were rich in content and address specific, relevant areas by building upon previously ascertained responses. My process was to compare responses from participant #2 to those of participant #1, then ask additional questions of #2 based upon that comparison. This

cross-component provided further explanation and revealed additional information lacking from the initial interview, and simply allowed the participant to express both general and individual answers, as described by Scollon & Scollon above. The process continued in a similar fashion with participant #3 being asked questions based on the responses of #2. This was reflected throughout the participant pool building a base of themes and responses, providing a means of effective triangulation and collection of useful data.

I also triangulated across my data sources. I discovered early into the study that there was a chasm between the academic literature and the information provided by the actual nurse participants. Nursing, as a vocational profession, depends heavily upon new research and proven/new practices to function. This is not entirely unique; however, many vocations do not experience the rapid changes in procedures and practices that occur in the healthcare sector. For this reason, I realized that the observations and the stories that the nurses told did not always correspond with academic and scholarly articles. This is in part due to the direction of many academic nursing journals, moving from interpersonal practice based research to healthcare policy and disease explanation. At first, this was concerning. However, I was able to bridge the divide by using information in the nursing blogs. Even though there were times the information did not liken exactly, it was generally possible to see and realize the issues, components and themes of the nursing narratives residing modestly in both academic and popular literature. When this occurred, I found myself asking more questions of the participant nurse and searching the blogs and literature more carefully. At the completion of the

interviews, transcription review and results analysis, I felt satisfied that I had triangulated across my data sources as well as possible.

Social Desirability

Conflict is a sensitive topic that may be perceived by participants to have future consequences if disclosed to superiors or fellow employees. Renzetti and Lee (1993) further our understanding of sensitive issues like participants' perceiving the research intrudes into the private realm, treads on areas that are sacred to them, or requests information that could lead to being condemned or disrespected by other parties. Therefore, people may resist outsiders investigating, questioning and inquiring into events that are considered sensitive (Yeager & Kram, 1995). Failure to handle this sensitivity would lead to reporting error. For example, a participant may, either intentionally or unintentionally, mislead the researcher due to sensitivity, potential embarrassment, threat, stigmatization or incrimination from another party or organization (Chaudhuri & Mukerjee, 1988). In some cases, (Frenkel-Brunswik, 1939; Meehl & Hathaway, 1946) participants experience self-deception where the respondent actually believes the self-report is true and accurate when it is not. Another concern is impression management, where the respondent fully and knowingly dissembles or falsifies the information (Paulhus, 1984). To overcome social desirability obstacles, I incorporated suggested and proven methods to reduce concerns of deception over sensitive topics. Such methods included:

- Creating semi-structured interviews (also see section – Triangulation).
- Posing open ended questions in a neutral manner (Mick, 1996).

- Leading with positive inquiring questions such as “What makes a good nurse” and “What makes a bad nurse” instead of direct questions of nursing conflict interaction.
- Providing scenarios and if necessary hypothetical situations.
- Allowing for ad-libbing, follow-up comments and probing questions (Sackheim & Gur, 1979; Thomas 1993), and
- Making probing and questioning comments to potentially penetrate the issue of self-deception.

Unfortunately, deception, whether intentionally or unintentionally motivated, cannot be totally eradicated. However, by being aware of the sensitive nature of the narrative through blogs and other participants’ stories, I was able to minimize potential contamination that deception could bring to the study.

Limitations of the Study

The approach taken for this study was not without limitations. Recognizing and understanding those limitations assisted me in producing an effective study. The recognition process alone did not overcome all limitations. It did, however, provide the basis for considering potential problems early and recognizing them throughout the research. These limitations included, but were not limited to:

As the researcher,

- I could have attempted to define a reality that I desired to measure and in doing so might have attempted to support my own definition within the study.
- I could have encountered social desirability, especially due to the compensation issue, from the participants in their attempt to provide answers they felt would be pleasing to the researcher and conform to the desired results (see Social

desirability).

- I might have proved to be biased toward the participants in either a positive or negative manner based upon my own attitude of the nursing profession (see Appendix D – Confession of the researcher).
- Due to the compensation for the interview, I might have encountered a dataset of specific economic-participants that were neither extensive nor diverse.
- At any time and without notice, I could have lost access or been limited in my interview and observation role with nurses, even if previously arranged and permitted by a hospital. This modification could have been the result of unexpected or new concern over free entrance to other individuals seeking to interview or speak with the nurses.

For the participants,

- The study might have become too costly due to time spent and compensation (e.g., for time off, childcare or travel expenses [gas and parking] to the interview site).
- They might have been bounded in their own awareness and hear only what they desired rather than the intent of the questions, responding at the moment in a manner they may later have wished they had answered differently.
- Taking the TKI assessment prior to the face-to-face interview might have skewed or primed a conflict story before the prescribed questions were presented in the interview.
- They might have been concerned that other members of the floor could have talked about them or used their name in the narratives they told. To alleviate this

fear, each participant was told prior to the start of the actual interview that use of actual names was not required and was, in fact, discouraged when addressing a specific incident where the parties involved could be part of the research study. In addition, participants were informed that names in the transcripts were changed to protect their identities and the identities of anyone referred to in the interview process. This relieved concern about name-specific "floor gossip" and instilled a level of confidence among participants.

Practical Support - The Pilot Interviews

Was there really something worth studying about nurses' and facework? Were there actual conflict themes that could be identified? Cupach and Metts stated that the management of face is a catalyst for the formation or the erosion of an interpersonal relationship (1994). Based upon this premise, it could be assumed that the management of face would be sensitive to a conflict in nursing.

I questioned whether the nursing stories really would provide examples of conflict interaction that could produce conflict themes and explanation of face tactics. Therefore, I conducted pilot interviews with three nurses representing different age-generations (I used age as the catalyst for the conflict stories). Each nurse agreed to a brief interview conducted during the shift. The interviews occurred over a period of four weeks at two inner-city hospitals with each participant questioned during the normal shift-time in an unobtrusive and casual manner. Each of the interviews occurred spontaneously with minimal investigation into the participant. The three participants are registered nurses. For purposes of the study, they are known as Rachel, a mid-20 year old charge nurse in the Emergency Department; Julie, a late-40 year old in the day surgery department; and

Iris, a near-60 year old working on a medical-surgical floor.

The participants were asked to perform a simple task: tell a story about how working with different age generations of nurses affected their ability to perform the nursing task and whether it created a conflict for them. It was not the purpose of this pilot interview to detail the questions created for the full study, but rather to test whether face tactics and conflict themes are easily seen within nursing floor stories. After completing the interviews, I was surprised at how easily the issue of face and conflict emerged in the stories. Each interviewee talked openly and freely about conflicts and/or interactions with other nurses of different generations. From the stories and my tentative conclusions (as shown in Appendix I), I was able to determine that conflict and face tactics can be observed and examined within nursing 'floor stories' and these narratives can contribute to the research in conflict themes and face.

Personal Criterion about Cultural Assumptions

Often, cultural research is trademarked by its approach to investigating the interchange between lived experiences, discourse, and the social context (Saukko, 2003). This research study assumed that there does exist an empirical and researchable event regarding interaction between nurses based on age, experience, education and practice. However, the issue of cultural or group differences was not the rationale for this study. Instead, it provided one of several catalysts which create the conflict to be studied. As noted by Gursoy, Maier & Chi (2008) it is not surprising that in our current culture people are concerned with generational work and the conflict that comes from employee motivation, satisfaction and behavior (White, 2006). Therefore, we can presume that nurses from different groups will come together as they perform their job in the shift

environment, bringing with them their various perspectives, thoughts, characteristics and values. This study's main focus and concern was the examination of the facework employed by nurses experiencing various conflicts to save, restore, or maintain face with another nurse.

Specifically, the study looked at conflict stories, their themes and the face techniques and tactics that an individual employs when in dispute with a fellow staff member in a work environment.

Chapter Four: Themes in nursing conflict interactions

"Everything that irritates us about others can lead us to an understanding of ourselves."

Carl Gustav

Overview

As I listened to the stories of conflict, certain themes reappeared from nurse to nurse. At first, these stories seemed like stories of random conflict with no pattern or purpose. However, certain overarching conflict themes began appearing (e.g., ethics) that provided greater understanding. From these themes, I developed descriptive theme titles to build a portrait of the profession and the overarching conflicts it encounters on a daily basis. These titles not only describe the issues, they focus on why these issues are so integrated into today's profession. The magnitude of the conflict, and the life implications they hold for nurses and their practice, became clear in the passionate and powerful telling of these stories.

Historical Nursing Themes

Over fifty years ago, Hildegard Peplau, professionally and academically recognized as an expert interpreter of interpersonal relations in psychiatric nursing, wrote a three-part series on nursing themes in conflict interaction. Miss Peplau, of the Pottstown Hospital School of Nursing, theorized that nursing conflict interaction (nurse to patient) can be categorized as one of three main conflict themes: power, safety (security) and stalemate (Peplau, 1953a). All other interaction themes, Peplau concluded, were subcategories.

Power, Peplau's first theme, is viewed as the ability to think, act and feel a sense of control, manipulation and/or exploitation of another. This power over others in a nursing interaction creates the sense of personal power that presents itself when nurses find themselves in a confrontation with patients, physicians or fellow nurses (Peplau, 1953a). Peplau's second theme, safety, identifies the joint human goal of satisfaction and security as it relates to the sense of feeling safe from the attacks of others (Peplau, 1953b) or being placed in a compromising situation. Stalemate is seen as an obstacle or interference to progress which creates a shared sense of hopelessness by one or both parties (Peplau, 1954). But why is Peplau's research important? As the research relates to the nursing profession, Peplau's peers of the 1950's (as well as those of later years) viewed her themes as a foundation not only of nurse-to-patient interaction, but one which was applicable to nurse-to-doctor and nurse-to-nurse interaction. Therefore, for many, Peplau's interaction themes provided the initial groundwork for nursing interaction theme development.

Nurse-to-nurse interactions in the in-person interviews reinforce the finding that Peplau's three themes—power, safety and stalemate—emerge as overarching, broad nursing themes. But do Peplau's themes dig deeply enough into the contemplated meanings and thoughts of the modern nurse? Contemporary thoughts, stories and attitudes demonstrate that new meaning can be realized beyond Peplau's broad themes. Though some new themes fall within Peplau's theoretical structure, others reside outside of her categories creating a further robust set of nurse-to-nurse interaction themes.

Conflict Themes

Every nurse had at least one story of conflict interaction. Some of the nurses had memories of interactions reaching back into their early years, identifying instances of distrust and concern over the ethics or procedures of another nurse. Many of these issues had occurred over and over again in the nurse's career defining specific themes with which they fundamentally identified. These themes of conflict interaction related directly to the profession and helped explain why they nursed as they did even though their approach might differ from others in their industry. Furthermore, it gave the nurses a justification for continuing their unconventional methods while recognizing the existence of other methods and acknowledging the differences between them. It was not rare for a nurse in the interview to say "I'm just frustrated" or "the more I think about the interaction, the more distressed I get." No one identified "anger" as a response to the interaction, but "distressed" was common.

Specific excerpts from the study's nursing interviews are provided below. From the 94 systematically analyzed conflict stories, twelve themes were identified, given a title, and supported with stories and quotations. The results section includes the most compelling narratives that best display and portray the conflict interaction and the conflict communication themes of the nurses. Under each descriptive theme title is a listing of stories or quotations that provides evidence supporting the creation of the theme. Some themes are supported with multiple quotations or excerpts while others are followed by full narratives of a conflict interaction. After identifying each theme, I returned to the nurses' transcripts to reanalyze and detect other themes that might

accompany the primary theme in a narrative. In many instances, multiple themes could be detected from a single story. In composing this section, I elected to list only the stories or quotations supporting a nurse's primary theme. Many more quotations and stories have been recorded, but not enumerated. The following narrative excerpts below address Research Question #1:

Understanding nursing.

The nurses were not reserved in stating the current concerns within the profession. Originally, I had not planned to approach the research from the standpoint of "problem areas" in nursing. However, after the first few interviews, I came to realize that the nurses wanted to talk about what bothered them about the profession. Based upon the comments, and as a means of better understanding a complicated profession that has to change almost daily, I developed the following list of excerpts addressing the nurses' concerns.

"A majority of conflicts is one Nurse insulting another Nurse's skill level. Like I said before, we're all good at some things; we're all bad at some things. Some Nurses will really attack the other's weak points just to make themselves feel like they're a better nurse." Jacob

"In nursing…I think you really ought to look out for each other, because a lot of times mistakes can be pushed off onto the Nurse, when it really wasn't the Nurse. There's a lot of that going on…" Jasmine

"You have to prove yourself to everyone. You have to prove yourself to the CAs (Certified Nurse Assistant), to the Managers, to the people pushing the food. You have to - - to the people cleaning the carpets." Janice

"I am a student. But, everything I've learned on this Floor is going against everything I'm taught in my textbooks in the Degree program,' and, you know, 'I am free slave labor,' no, I said, 'I'm free labor." Karla J.

"They have a really, hard time finding Nurses. We're always under-staffed, and. I think it would be hard to get someone fired that is, they don't like to fire people….they would have been re-assigned." Janice

"So, if you have a problem, you usually go to Rehab…We go through our own Program, so if you work in a hospital, and they find out you're stealing drugs, they - - you go through your own rehab program - - Nurses take care of it themselves." Janice

The nurses are passionate about their profession and the quality of practice in the profession. They stay in tune with what is going on around them and they continually evaluate their professional interaction and how it can affect them personally and professionally. As they nurse, their commitment to the profession and the patients shines through but not without signs of frustration regarding their fellow nurses. Nurses are concerned and a bit skeptical of each other. They may judge others by their own thoughts, morals and practice style. At the same time, they are forgiving…to a point. This became more evident as the conflict themes evolved. The conflict themes emerged from their stories which identified conflicts that occur between nurses due to their interaction with each other.

Theme 1: Since when it is OK to do that? A question of ethics, morals, legality and best practice.

The nurses report various instances and issues that directly go against their training, morals and ethics. This theme is presented as the first of the conflict interaction themes because it was of greatest concern for all the nurses interviewed. The reason? They report that they are concerned about losing their own license if they are implicated in an action that can be considered unethical, illegal, or a danger to the patient. The nurses did not originally volunteer many of these tales but, as their concept of good nurse/bad nurse was explored, many of the nurses began to share more egregious stories—the ones that made them shake their heads in disbelief that such a thing would happen.

The first narrative is not of a conflict interaction between nurses at the moment of the event but, instead, one that developed later out of a concern for the action and its possible consequences on the nurse telling the story. Looking back, she exhibits regrets. This story is highlighted first because it shows the level of morality and ethics, in addition to legality, that nurses encounter.

> "I loved working with David. David was a Korean War vet …he had adopted this guy, and it wasn't his son. David called him his nephew. He had been a drug abuser and had had a rough life, and when he came [in], I knew he was David's 'nephew'…he was HIV. This is one of those examples where you're afraid to say, but, like, his order for morphine was like five [5] and I would give him ten [10]. It pissed me off that the doctors wouldn't order anything more. But you have to

call for Order, but, I'm like, give me a break. He's dying. He was dying. I wasn't doing anything because I wasn't trying to hasten his death. I was doing it because he was obviously in pain. That was one of those examples that I did that. I did that one [1] time for him, and David practiced that way, too. And, so, that's kinda where I got that it's okay to do that. The Order was for eight [8] and I gave him ten [10]. This is at a time when we weren't capturing our narcotics as closely as we were, I could have gotten caught, and in big trouble because it would have showed that a computer needed to dispense eight [8] and ten [10] was dispensed and the computer would be looking for where did the two [2] go. And when you waste narcotics you have to have a second [nurse] to see [the waste], so I could have gotten caught. Basically I did more than ordered. So I would just do that every now and then with him and I think it was cause of David would do that with like Morphine and other medicines. But, I liked working with him [David], too." Kathy

Kathy's story is very enlightening in terms of how some violations of ethics and morals are justified by nurses. Kathy was not a new nurse but an experienced RN with 10 years of nursing experience, a BSN and some graduate work toward her MSN. Although Kathy did not initially question David's ethics, she realized later that going along with him could result in her own dismissal. This is an example of how alert a nurse needs to be to question another nurse in daily interaction. The story represents the issues of ethics, morals and legality of questionable practice all rolled into one incident.

Most of the nurses related stories of conflict that resulted from questioning the ethical and moral actions of another. The theme "Since when is it OK?" implies that the nurses not only questions the action, knowledge and intent of the other, but also makes a judgment based upon their own thoughts, beliefs and education or training. Nurses were typically found to be less vocal (Cavanagh, 1991; Valentine, 2001) than individuals in other professions. The nurses interviewed said they would usually remain quiet about an incident unless they saw potential patient safety issues. In these situations, as in others, the nurse may or may not respond to the offending nurse; however, usually the nurse would not approach management about the incident.

Nurses performing actions and practices that are considered questionable by other nurses were plentiful in the stories collected. The most common of the actions involved medications, similar to the first story told by Kathy. In the following story, Patti questions the ethics and the practice technique of the night nurses.

> "…so, they give their patient too many sedatives, too many narcotics, and that patient's really sedated in the morning. I have to deal with it. And I need to follow up on it. I need to explain to the family why Grandma won't wake up, you know. But, I'm going to guess that the night shift probably doesn't care because they want the patients to sleep all night. But the doctors, I mean, they're in a rush too and they'll do whatever it takes to keep the Nurses quiet and try to keep the patients quiet. So, as long as we're not hassling the doctors and they don't really mind if we ask 'hey, this patient needs something for sleep' but it's very easy for them [night nurse] that if the doctor took away a medication that they want to give

-- so the patient will sleep -- they can just call the On-Call Doctor. Because at night it's a different doctor than the doctor who's there during the day. So they just call the On-Call and say 'hey, can I get a prescription for whatever.'" Patti

Nurses make critical decisions daily. In many of these decisions, the issue of legality emerges as a serious concern. The following story from Jane describes a conflict interaction between two nurses as one takes medicine out of the "Pixus" – the medicine dispenser. Jane relays this story as a bystander that agrees with the action of the nurse questioning the actions, ethics and legality of the nurse removing the medication.

"…It was the Pixus machine. It's like a medicine vending machine. So you need a code to get in it and we have everything in there from aspirin and Tylenol up to like some morphine and there's all sorts of stronger drugs. So, you type in the patient's MRN number and you type it and then you find them, and then you type in the drug that you want. And then a particular drawer opens.

"There was kind of a line to get into the Pixus cause it was busy. I heard the woman [nurse] ahead of me go 'what the hell are you doing', and I guess she, I couldn't really see exactly what was going on, but apparently a Nurse took a Tylenol, some regular Tylenol, and then popped it in her mouth and had a little glass of water. The sink's right there. And then took the rest of the meds out for her patient, and the little cup and everything. The Nurse said 'I've got a headache. I'm taking a Tylenol. Butt out, leave me alone.' And the other Nurse is like 'you can't do that. That's under the patient's name. They're being charged for it.' You can't take, we have our own Tylenol. Like, at the Nurses' station you can take,

you're not supposed to take it out of the Pixus. She said 'I don't have time to go to the Nurses' station to get a Tylenol and come back.' I was watching that and thinking.

"I'm sure you've heard about other Nurses stealing drugs and Nurses taking patients' drugs and on a job, and, so it's a very sketchy thing to actually take medicine out of the Pixus and take it right there. It's a big no-no. …because the patient got charged. Because you enter the patient's number in, then you get the patient, and then you type in how much you're taking out. You would say, you know, one [1] Tylenol, or you would say five [5] milligrams of morphine. Putting the wrong number in that she was taking out two [2] and she took out four [4]. Actually consuming them herself is definitely wrong. Obviously she felt like it was okay cause she did it with a whole bunch of people all around. It wasn't like she was trying to hide it or anything. She did it blatantly out in the open.

"In my view though, everything in the Pixus is sort of sacred. You don't mess with that. You don't take any of that. It's just - - You don't go down that road. Because who knows if they're taking Tylenol or Vicodin or Valium or what. In Nursing School they tried to, and it's like, hearing all those stories, but I would hear lots of time of Nurses taking out, you know, some sort of drugs, say Morphine, and not even taking off the syringe of the bottle and then not giving it to the patient and then just injecting it into themselves. Just not even giving it to the patient at all." Jane

The following story is an example of a conflict interaction due to a nurse questioning the practice of another nurse. The concept of best practice, considered as what is best for the patient, can differ from one nurse's point of view to another. Nurses do report that they realize these perceptions can be subjective. This story, told by Janice, is a personal example of a failure to provide for patients under the concept of best practice.

> "Yea, there was a Nurse who never, ever looked in on her patients. She was always at the Nurse's Station, her patients were neglected. You would go in, if you had to pick up her patient when she left, you would just end up with a mess. Because she was like, 'Like I can't see really well. My sugar must be really high'. Like it totally alters how you think, if your blood sugar's a, you know, eight hundred [800]'. I was like, 'you're gonna die'. And she smokes a lot, and she had fake nails, which was huge. Whenever I would chart, I'd have to do Chart Audits, and one [1] of the questions was. 'Was this Nurse wearing fake nails'? And I always had to check, 'yes', like, you know, cause it has that fungus that can kill people. It was like, 'you're actually killing our Patients'. She was like, 'oh, whatever, they look great'. She wouldn't change even if you're like, 'these nails - - you know -- you can't wear fake nails'. "Janice

The next two stories come from Juliet and Brooke. In Juliet's story she directly disobeys her supervisor stating that issues of ethics, safe nursing and patient care were a concern. This conflict interaction between superior and subordinate communicates the

level of frustration that a nurse may have when mixing personal ethics with a supervisor's directive.

> "….so, she could get her Demerol fix. She was always - - diagnosed with a low back pain, which nobody could prove, or disapprove - - she's a little, tiny thing, probably a hundred pounds. She would come in with all her garb, you know, her night negligee, and her robe with a, you know, an ostrich stuff. I mean, she was there to stay. That's - - that's what she was there for. And, this particular Doctor would always write, Demerol a hundred milligrams four [4] hours, as needed.
>
> "One time he wrote an order that she could have it, the Demerol… it was PRN [as needed], it was not designated, the hours? It was every two [2] to three [3]. And she would call, and she wanted the medication at two [2] hours, and I refused to give it, because you don't give milligrams of Demerol two [2] hours later, to a hundred pound woman, or anybody that's a hundred pounds. I mean, you could put their life in danger. However, she probably wasn't absorbing much of it, because it was the scar tissue [at the injection site]. So, we started doing it in her legs, which, anyway, I refused to. I said, 'she couldn't have it. It was too soon'. So, she called her Doctor, he called me, and chewed me out over the phone. And I said, 'well, I'm not going to give it. That's not - - that's dangerous'. And if you want to have someone else give it, you can. But I'm not gonna give it. So the Charge Nurse ended up giving it. But, I never did give it, because I thought it was - - it was not safe to be doing that. I wasn't gonna give it, because if something happened with that, I didn't have a leg to stand on. But the Charge Nurse seemed

> to think it was not questionable, cause she went ahead and did it. She said, 'well, you know, you need to follow the Doctor's orders'. And I said, 'well, this is not right - - this is not a good decision. This woman is a drug addict'. She said, I'm not gonna make you give it', which she couldn't make me give it. But, you know, she was gonna follow his orders, because he admitted a bunch of people there [to the hospital], and they needed the business.
>
> "It wasn't the right thing to do, in my opinion, when PDR [Physician Desk Reference] specifically states you don't give Demerol, a hundred milligrams IM more than three [3] to four [4] hours." Juliet

In Brooke's story the question of ethics remains the central issue. Unlike Juliet, Brooke obeys her supervisor, but later she regrets her decision realizing that corporate pressure influenced her ethics of patient care and security. Brooke's concluding statement is personal disappointment and a concern over the future competence of her supervisor. These issues were later reported by Brooke to be the catalyst for her early resignation from this employer.

> "I didn't know if that was something I should bother the Doctor about, cause they can sometimes get anal over something [the patient was being discharged with an elevated temperature, fever]. So, I didn't really have the judgment. So, I asked her [the charge nurse] opinion, and she was like, 'oh, no, you know, that's no big deal. Let's just get her out of here'. And I was like, 'there's something gone wrong', If anything ever happened, it would be down to me, and my license. I was concerned, but she was like, 'no, let's get her out of here, so that we don't have to

deal with things later happening. And opening a new can of worms, if she has an infection, and then we'll have to do this, and that, and, you know, so'. I ended up following her advice, and it was a bad decision, because she ended up having to go to the ER the next morning. Saturday morning she had to come back to the hospital. And then put her back in the hospital, starting antibiotics, all these things that would have been caught, you know, had I followed my gut. But I was - - I was second guessing myself, because she had more Clinical experience, and I thought she knew what she was doing. So, I didn't want to confront her about the fact that I disagreed with her.

"But, looking back, I don't think she was a very good Nurse. I lost respect for her, and I was really disappointed in myself, because I was like, 'you know, you shouldn't have done that.'" Brooke

In these stories of conflict, the nurses report concerns about ethics in the workplace, particularly regarding themselves, their patients and the quality of care. The nurses frequently use egocentric statements signifying an absolutist position; however, they also reflect a dispositional view that certain individuals react in certain ways under specific conditions (Broad, 1944-45; Firth, 1952). In their stories, they tell of nurses making questionable and unethical decisions based upon utilitarianism – the moral cost is determined by the usefulness or benefit of the action (as in the morphine story told by Kathy). These nurses also reported in their stories that as one nurse takes certain actions in a questionable situation, other nurses were directly affected concerning the question of ethic, a similarity to the Moral-sense meta-ethical theory. Every person maintains a

moral faculty that insures he or she will have a certain kind of reaction – sympathy, approval, etc… – when faced with another person's behavior. This reaction is dictated by whether the event is viewed as right or wrong in the eyes of the individual, prompting a moral feeling (Kuklick, 1969). It was from this moral feeling, as told by the nurses, that the nurses lose respect for co-workers and supervisors triggering an interpersonal conflict. Of the twelve conflict themes identified, the theme of 'Since when is that OK' was told the greatest number of times and became the most memorable with the Moral-sense meta-ethical theory being visible through the stories of conflict.

Theme 2: You really don't know what you are doing! A questioning of training and education.

This section explores the theme of nurses' training and competence through their stories of conflict. Nursing is not a "one size fits all" when discussing education and training. Currently, RNs (Registered Nurses as licensed by their state) must possess a degree from a post secondary institution. This degree can be a bachelor's degree (BSN) from a 4-year university or an associate degree (ADN) from either a 4-year university granting associate degrees, a junior college or a community college. Therefore, RNs come from varied backgrounds in terms of degree programs and clinical training. The BSN see the ADN as clinically experienced but lack critical thinking skills and theoretical knowledge. The ADN view the BSN as just the opposite—lots of book sense but limited or no "on-hands" training and knowledge. And the third element of professional nursing, the LPNs/LVNs, often enters the profession with neither the post-secondary degree nor the clinical or theoretical knowledge required to perform in the

current healthcare arena. So, the conflict between degreed education and skills becomes apparent.

The following are excerpts come from nurses talking about education, licenses and training from their individual points of view. In each of these excerpts, the nurse approaches the topic in a matter-of-fact way, justifying her education while downgrading that of the other, viewing the latter as inferior in training and practice.

> "You can't always tell that who's who or whatever. Only, when you're talking about education and in some cases you find that ADN who's like, you know, could barely get through school, never went through school again, hates school. And then you find the one that's saying 'you know, just because of financial reasons I had to go this route." Abigail

> "A two [2] year degree. And it's kind of a joke - - we say. I don't know if it's discriminatory. It probably is. But they're not thought of very highly. I don't think they're of the nursing industry, so they call them 'two-year wonders.'" Donna

> "Clinical? There's the whole thing about, if you go to a Community College, the rule is you'll get hired faster, cause you - - you have more skills. And the '4-year university students', they're not gonna - - they're not gonna hire you as fast, because you don't know your skills as well. But they (Community College) don't do any theory. They don't do any leadership skills. They do all their skills really fast, because most of the students have CA [career nurse assistant] backgrounds. Like our (university) students, they are not. They've never been in a hospital. So,

we have a huge ramping-up. Basically we, we have research. ADN's do not any research. They don't look at any research. They don't compare. They don't do a lot of evidence-based practice." Janice

The above statements reveal judgmental tendencies and competition regarding the education, licensing and training of fellow nurses. From actual hospital instances, we see conflict stories that support the conflict theme of questioning another's training and education. The following story describes a situation where licensing is not an issue (RN versus LVN) but subconsciously the nurse, Juliet, compares the lower license of the LVN to a lack of education. She implies that the LVN does not recognize the higher level of knowledge of the RN. This statement was later explained as meaning that nurses of different education and license may not ask another for advice, especially if they view the other nurse as inferior educationally or in license.

"I had an LVN that hung a piggy-back. She hung it below the thousand - - the bag that's a thousand cc's. A piggy-back was about fifty cc's. Of course, it didn't run in. Because you have to hang it higher. Otherwise it will - - the larger bag will overtake gravity. She kept arguing about that, cause she didn't understand the logistics, nor would she take - - she wouldn't receive instructional criticism, She'd been a [nurse] lot longer than I had, but she - - she didn't understand the principle behind it. And, of course, her piggy-back was not going in the main IV bag; she never wanted to admit it. Never wanted to admit that - - that she was wrong. I said, 'you have to hang it above, because it's a smaller bag'. And basically, when she left the room, I think I just switched it around, because she wasn't going to

change it. I just went back in there, and changed it, cause it was wrong. She wasn't going to do anything about it.

"I probably should have written her up. But I didn't, because I hadn't been there but maybe a month, or two. I felt belittled, because I did know what I was talking about. But, the point is, is I didn't trust her with anything, because she didn't know. She didn't know the basic principles. Oh, she never thought I knew anything. I was the Charge Nurse, that's why I would have gone in there, and changed it. But, what she didn't understand was the principles. She wasn't a Critical Thinker. But, if somebody came up to me, and said, 'you know what, this is not the way to do this. You've got it reversed'. And they - - had more education than I did, like the Doctor came in there and said that. You know, I would probably listen to them. And then I may go out there and check the info - - the literature about it, to make sure that they knew what they were talking about, if I had a question in my mind. Now it may have been dripping a tad, but it wasn't going in at the rate we needed to deliver that medication quickly, the antibiotic, or whatever it was. It didn't need to go over eight [8] hours. It needed to go in, and be done'. She's making an error that is gonna cause an injury, or a - - it's a medication error. It's not delivered in the proper - - the medication's not being delivered at the proper time. So, that's a Medication Error." Juliet

The nurses' stories pose issues of education, training and licensing, but seldom communicate that competence is based upon the individual or the personality. In the interviews, each story of competence was prefaced with the other nurse's qualification:

ADN, LVN, diploma nurse, etc. I interpreted this gesture of comparing education/licensing credentials as a form of competence driven social comparison, a concept identified by Festinger (1954) and advanced by Gilbert et al. (1995). This issue of competence also aligns with Berger et al. (1977) expectation states theory, a theory concerning how people assign a competency level to each other by means of 'status characteristic' and/or 'performance expectations'. Both of these theories relate to the concept of educational status of the nurse (BSN versus ADN), license status (RN versus LVN) and performance expectation (Juliet realizing early in the altercation that any IV bag hung by the LVN was positioned incorrectly and not pushing the desired dosage of medicine, resulting in an under-medicating of the patient).

Nurse participants told of other nurses assuming they were acting correctly when the actions were later realized to be incorrect, harming the nursing process and possibly the patient. Yet, they were unaware of the wrong action because they failed to ask for advice or verification. These situations relate to the research of Kruger and Dunning (1999) that incompetent individuals do not know they are incompetent. And because they do not ask or inquire of others, they remain incompetent. Therefore, this section titled *'you really don't know what you are doing'* is grounded in the theories of competency and expectation states.

Theme 3: Don't make me come after you! – Dealing with slackers.

The nurse participants report that, in general, slacking off by another nurses create additional work for them as they come onto their shift. As conscientious healthcare professionals, they feel the need to 'follow through', picking up the pieces left behind as

to avoid an issue of delay in care for the patient. The reason for the slacking of nurses is varied. From the stories provided, it becomes clear that many times the nurse is ready to chase down the slackers and make them do their job correctly. Thus, the theme title of "don't make me come after you".

In the story by Kathy, she shows a level of frustration—she already knew what was ahead for her. Kathy's story illustrates an instance where the other nurses on the floor or unit all knew who was slacking off—the reputation followed them. Lucille, in Kathy B's story, is an older British nurse who has been in America for many years. Lucille is aware of the correct procedures to follow; however, she continues to practice in her usual way, leaving work for the oncoming nurse to complete.

> "The Nurse that I followed yesterday - - tends to leaves things for you or that makes more work for you. They seem to be lazy. They don't seem to be following up on what they're supposed to be doing and so when you come to work, you're like, you get, you're frustrated and angry that you're even following them. You're like, 'huhhh… I'm following Lucille again. Great. I know I'm gonna have to do my work plus the work that she didn't do.' And that's what happened last night. I came on and she's already making excuses for something that should have been done at the beginning of her shift and I'm like, 'okay, what just needs to be done so I know what I need to do to help?' And so, an Order had been written for a blood transfusion at ten-thirty [10:30]. The blood should have been done by the time I got there, but…there might have been some miscommunication between her and the Laboratory, but, you know, that first unit wasn't hung until seven [7].

> And then…when I came to the desk and was like, 'huhhhh' and everybody was, they were like, 'I bet you it was Lucille.' They all knew, already knew who I had followed and then the talk started about her and I'm like 'oh, so, she's a problem for everybody' and, so, everybody had a story and I'm just, like, oh, this is awful. She's [Lucille] pretty pleasant and, you know, doesn't make apologies and she's not mean about it or ugly about it. She just seems to be, like, 'ho-hum, like, I'm leaving you all this stuff to do.'" Kathy

The interaction surrounding failure to chart, giving report and the completion of shift task became a focal issue within the nursing interviews of on-the-job conflict. The following story represents a conflict interaction resulting in the frustration of the victimized nurse.

> "Reporting off to the next person, you know, what did or didn't get done. As a Manager, as a Floor Nurse, just seeing, George does not Chart. I have no idea of what he did. He never Charts anything for example. Or whatever activity that maybe was supposed to be completed on nights. Like a weight. Oh, my gosh, that was huge with dialysis patients. That can make a Day Nurse, explode, because then we're not going to have the right weight before they go to dialysis." Abigail

Jane portrays a different issue in nurse slacking. She gives an excellent definition of 'nursing slacking' as it refers to patient care. Then Jane moves into her view that generational differences are a reason why nurses sometime slack on the job and/or patients.

> "Slacking off is not caring for the patients, sort of ignoring them when they want things that aren't necessarily critical but they want a glass of water, they would like some more pain medicine or something. Sometimes Nurses say, 'yeh, I'll get to that when I get there' and they'll be sitting on their butts, pretending to chart." Jane T.

Concluding this theme, Juliet best explains the reason why slacking is so despised by the nursing profession. Not only can a person lose their license for not performing the job, but the follow-up nurse, too, can pay the price for their predecessor's failure to perform. Worse, the patient may pay the ultimate price, a statement that Juliet makes regarding the detriment of slacking nurses.

> "It's someone that really has a 'Care Less Attitude'. That is not - - they are doing things that are not helpful to the Patient, or to the other Caregivers around. That they're doing stuff that's actually detrimental, and then they're not good in their note taking, or their note - - describing it well on their Nurses Note, so people will know what's going on. And that causes other people to make mistakes - - if they don't Chart properly, or make precise entries about how much medication was given, or how much of this, or when it happened. A lot of medications can be error, if somebody didn't - - it wasn't charted properly. You can give something - - you can give it too late, or worst." Juliet

This conflict theme of *'dealing with slackers'* follows the research of various theorists. Most notable is the concept of the free rider, someone who believes their contribution to the process is small but also believes that the probability of success is

very good due to the number of participants involved working toward the collective good (Klandermans, 1984). The nurses expressing this conflict theme have several concerns that match multiple theories: First, that co-workers were not completing tasks and leaving them for others but still benefiting from a positive outcome without personal cost (Free Ridership [Arneson, 1982; Coleman, 1988]); second, an expectation that everyone will pull their own weight even if it entails extra work (Principle of Fairness [Rawls, 1971; Arneson, 1982]); and third, that the offending nurse might weigh the individual cost of completing a function against the potential personal benefit of a completed task (Resource Mobilization Theory [Oberschall, 1980]).

Theme 4: So what's your problem? – Nurses not helping out other nurses.

As an unspoken rule, nurses help each other, jumping in and moving quickly to handle a situation. Perhaps it is the nature of the healthcare industry that dictates instant action when a crisis arises. This teamwork attitude is commonly conveyed by nurses as it is taught in nursing school—as a means of providing quality patient care. In stories told by the nurses, strides were made to elaborate that nursing teams work coherently and in unison to the benefit of the patients. These types of stories are not few, but many. But just as plentiful are stories of conflict interaction surfacing when nurses speak of the non-helpful teammates. The following stories all have the same common thread, a nurse who is overloaded and another nurse that remains inattentive to her needs and fails to assist when asked.

"….She [the charge nurse] like, she definitely could have, you know, helped. When you come out of the room, she's sitting there at her desk. Doing nothing,

> this upsets me. And, you know, the communication that I gave was, 'do you think you can help? What should we do? I mean, why not, you were sitting at your desk?' …I know I can definitely do my job. But, it comes to a point where, yea, it can be overwhelming. There are five [5] people. I mean, I can take care of five [5] people. But not when two [2] right there, they're all having problems, they all need I.V.'s, they all need medicine. One [1] of them you have to go to CAT scan with, because you don't send them by themselves. You've got to leave the others in the room. Nobody's really watching your other ones. It's just a total much. I was frustrated, because I couldn't be there for all of them. And, I guess just angry, because I like to have everything in order. Make sure everybody's okay. I asked her, 'can you come and help me?'. And she said 'It's one of your patients, what else do you want me to do?' And then, I'm like whatever. I'll just do it. I'll just figure out a way." Helen

Similar to Helen, Jane is overloaded with work and in need of help; however, her pod-mate becomes combative and confrontational when approached.

> "I had three [3] ambulances arrive at once and they were all very critical. They had, a person was having a stroke. I think a person was having heart attack and MIs, which is heart-related problem. And the other person was having a seizure. They all arrived at once and there was no way I could handle it all. So, what you do is you look for your pod-mate. The other Nurse, we'll say her name is Harriet. So I was looking for her to say 'hey, could you give me hands' and I couldn't find her. We all carry little phones on our pants there and so I called my pod-mate

Harriet's phone and she didn't answer and so, I mean, I was just running around, doing as much as I could do, doctors were screaming at me and, you know, I'm trying to keep the ambulance there, the EMTs there. Like, don't leave this patient alone, I'm trying to get another person over here. And then, finally, I don't remember if it was the LVN or another Nurse or Tech, said 'oh, Harriet's in the break room', and she was sitting there with her phone turned off and she was like 'yeh, yeh, yeh, I'll help you when I'm done with my break.' This is an example of, I mean, that's when you drop your lunch and your break and you take it later and you go and you help because people are dying. People need the Nurse immediately. It was incredibly frustrating and she was an older Nurse. I knew that she was supposed to help me and I wasn't trying to make my load easier, I was just doing what I was supposed to do. All of her patients, though everything was under control, nothing too bad was going on with any of hers. And, you're supposed to have your phone on all the time. You answer the phone when you're on the toilet.

"I went into the break room. There were few other people in there and I asked her to go back to the locker room where there wasn't anyone and I said "I really need you to help me right now. I tried calling you. You didn't answer your phone.' She was like 'yeh, yeh, I'll get there when I get there, I'm taking my lunch.' And I said, 'but this is really important.' and she was like, she was just kinda blowing me off and she was checking her personal phone, checking her text messages and stuff and just not taking me very seriously at all.

"She did come out. She was kind of cold to me the rest of the night. We didn't really have much chance to interact because we were both so busy. She [did] say at one point - - she was going to go to the bathroom and she said 'I'm going down around the corner to go to the bathroom. Are you going to be alright or are you going to call me when I'm in the bathroom?'" Jane

Why would a nurse not help another in need? Was it a lack of concern? Was it an issue of laziness? Or was it a personality issue? The interview information did not address or answer these questions; however, the literature does give an insight into the behavior of 'helping'. According to Ungar (1979), helping behavior centers around two competing response tendencies: sympathy for the other person; and the desire for avoidance stemming from reduced attractiveness to the person in need and the discomfort associated with helping them. This theory, regarded as the Stigma of Helping (Ungar, 1979), moves the issue of helping from situational to interpersonal. The nurse in these stories did not mention personality as an issue for conflict but alluded to lack of interest or motivation for the non-involvement. Unfortunately, not enough explanation was offered in the stories to pursue the reasons.

Theme 5: My way or the highway! – know it all and not listening nurses.

The title of this conflict interaction theme implies a 'hardheaded, stubborn' nurse who will not listen to other nurses. This title statement is supported by the interview comments where nurses complained about the inability to communicate and/or change a procedure with another nurse. This becomes apparent when considering the concept of critical thinking and clinical skills versus doing it the "old way," a reference often

addressed in the stories. If you look into the comments, you can detect that critical thinking is the ability to discern situations and make proper decisions and assessments based upon knowledge. At the same juncture is the concept that making recommendations toward better nursing practices and patient care is better for all parties involved.

The following story comes from a nurse who is frustrated by the lack of support and acceptance for what she considers alternative nursing and operational processes. In the story, the proposing nurse is at least a BSN degreed nurse proposing to another nurse (education not known) practices and procedures that she perceive as an improvement to the current practice. The frustration of these nurses lies in the arena of 'just try it', or 'just hear me out.'

> "Anytime you asked her anything, very defensive. [I would ask] 'what do you think about trying just - - let's just try this? Let's just try it. We don't have to do it this week. We don't have to do it next week. But, let's just entertain this idea. Just go home, and think about it. Let's see maybe if we - - if we transition patients from this area, to this area, to this area, and we did it in this manner, as opposed to how we're doing it now, let's see if that would work a little bit better, for the Staff, for the Patient, and for the Doc's. So, just get back to me on that. But I'm just gonna throw it out there. I'm just offering this as a suggestion that there are different ways to do things'. And she would almost immediately. She wouldn't go home and think about. Nothing, it would be, 'no, we're not gonna do that'. I'm just like, 'okay. No way - - no way we can try it'? 'Nope'. I just thought, 'wow,

here is somebody who is so dug-in on how she - - how things - - how she wants to do it, she wants to do it. Not how we're gonna do it'. And she's actually not even taking care of them [the patients]. We're the ones doing it. But, she dictated how we're gonna do it. It was very frustrating trying to deal with her. … [And] 'I'll pull money out of my retirement, before I'm gonna come back here, and do this'. It was just - - it was a 'lose-lose situation." Donna

This theme of *'know it all'* is similar to the previous theme of *'not helping others'*. The primary difference in the stories of this theme is the absolutist attitude that the offending nurse displays. This is visible in managers who ignore recommendations and fellow team members who ignore comments. Perry (1985) describes the absolutist position as: there are determinate rules of conduct that should not be violated except for consequential reasons. Absolutists are seen to exhibit irrationality, refusing to consider details of an issue or situation; however, they insist upon an automatic remedy by way of a blanket rule (Perry, 1985). This definition of the absolutist is visible in the nurses' stories and, as suggested in several of the stories, the absolutist's attitude toward the manager or co-worker leads to the interpersonal conflict between the two parties.

Theme 6: Just don't bother me with that! – Nurses disrespecting nurses.

Similar to the previous theme of nurses that are resistant to new ideas, a category of conflict theme from nursing interaction is nurses not respecting other nurses. This theme is commonly found in the workplace and can contribute to a barrage of reasons, including those primarily of age, followed by education and shift worked. The following stories represent nurses feeling disrespected, belittled and unappreciated by their team

members and managers. Though tenure usually plays a role in this concept of respect, organizational hierarchy often becomes the main factor dictating the course of the conflict interaction.

> "And the one that is my peer just talks me down and patronizes me. It does not feel good…. and, you know I'm gonna get my stuff done, it just might not be in the same order that she's going to get it done or the same way, you know, as long as it has the same outcome. And, you know, and it really bothers her that I'm not doing things her way. I don't feel like Nurses, you know, I don't think they're respected enough. I don't think they respect one another enough. It's almost like once you get your experience, too, once you kinda get your sea-legs, you know, you have to be in that Unit for about two [2] years. You don't really get the respect that you want, I guess. They don't really think you deserve it until you've been there for two [2] years." Karla J.

> "[I'm] just really aggravated. Like — it makes me mad that they think that because I'm newer and don't have as much experience -- which is true, I don't have nearly the breadth of experience that they do. But they think that I don't know. And, so it makes me mad." Patti

'Disrespect' is an element in several of the earlier themes of nurses in conflict and will be viewed as a common thread through several conflict themes. Specifically, the disrespect theme viewed in the current section reflect the concept of feeling 'Holier than Thou', a concept that Epley and Dunning (2000) describe as a prediction of self. These theorists state that, "people may find it more difficult to accurately predict their own

behavior in a moral dilemma than to predict accurately others," (Epley & Dunning, 2000, p. 868). This error in self-analysis and prediction may result in a 'holier than thou' sense for individuals leading to a cynical view of their peers and coworkers (Epley & Dunning, 2000). In the nursing stories, this concept applies even without a moral dilemma. Specific stories (as in the example of Karla J.) reflect nurses talking down or patronizing fellow nurses in a disrespectful manner. Other stories, such as Patti's story, tell of nurses that are too busy to answer or provide information. Through their disrespectful approach, they are communicating 'you're unimportant'. 'Holier than thou' was viewed in several stories of interpersonal conflict; however, it was not reported as one of the top issues for interpersonal conflict by the nurses.

Theme 7: Just do your job! – Stop brown-nosing and wasting my time.

Gossiping, brown-nosing, talking about home-life and bringing problems to work. These are all issues that nurses reported as instruments of conflict within the profession. Nurses most commonly reported just being tired of listening to their fellow nurses' talk about issues unrelated to patient care and practice. This issue is not isolated to nurses. All professions have the same discussions in the workplace. However, the nurses find these types of discussions take the attention off of the critical aspect of the profession – the patient, the doctors and the need to provide quality care—thus causing a higher level of frustration that led to more conflict interaction.

The first story is told by Donna, an older, seasoned and educated nurse who has worked in hospitals, corporations and clinics as a registered nurse. She reports that she has seen all kinds of nurses, those with problems and those without—or at least not

problems disclosed in public. Donna is a single parent. She works because she has to and she works multiple jobs to make ends meet. From her story, it becomes apparent that she goes to work for the patients and the income and not as a social gathering.

> "They bring their problems to work, instead of leaving them out in the parking lot. But, everybody's got problems. We don't need to hear it. We can vent, but don't do it while we're trying to take care of patients. …I said, 'we could all - - we could all come in here, everybody's got a story. You know, getting divorced, sick parents, sick kids, everybody's got a story. But you need to take that stuff, and leave it in your car. Don't bring it in here. It's getting in the way'. And I think she really listened to me. She got better for a while. And then she'd start - - she'd start to backfire. And I would just kind of look at her, and give her that look. And she'd go, 'oh, God, she's gonna start talking to me again'. And I said, 'you bet I am. I'm gonna take you by your little ear, and I'll hold it till you hear." Donna

The following two stories are listed as brown-nosing (and tattling) as the offending nurse is attempting to increase her status with her superior, sometimes at the expense of the other nurses. Both stories are told by nurses who recognize the situation and are frustrated with the surrounding events.

> "And so, I've been a Nurse for four [4] years. She's been a Nurse for three [3] years. And so, she's constantly change processes, and trying to implement new ones. And saying to me that, 'you know, that Dr. said I did a wonderful job today, and he loves having me around'. And I'm like, that's fabulous. So, you know, I'll tell her, and maybe this makes me a little two-faced. But, I'll tell her, you know,

'well, yea, we're all glad to have you around. That's - - that's why you're here'. But, in my head, I'll be like, 'do you want a gold star'? Like what?" Sarah

In the second story, Brooke, a young RN with two bachelor's degrees, is working at her first job out of nursing school. Brooke communicates frustration and tells the story almost out of despair, hoping for some type of advice on how to handle the situation. She sees the issue as that of tattling and brown-nosing but she does not know what to do personally to protect herself. She resorts to staying away from the offending nurse; however, she also explains that this offending nurse was a friend. However, she now feels betrayed by her friend's actions.

"…and, you know, going like, running off to the Manager, and telling her everything. And we just kind of felt like we felt a little betrayed. … I mean, I think she's trying to win favor with the Management. So, maybe she was also asked by the Manager to keep an ear out about what's going on in the Unit, and that would make her feel important. And wanted to like be the person to report back, or something. I don't know. … personally she's a very pleasant person, who actually had my [back]. She's actually supported me in other scenarios where, you know, I could have been in trouble. She was very understanding. So, you know, I think a lot of people respected her. Now I think it's different. I mean, I can respect her experience. …but I just sort of have been avoiding talking to her, because I never know what, you know. If something comes up, you know, I kind of keep my conversations with her pretty simple. You know, pretty cordial. I don't expose a lot to her. Even if it's a concern about practice, or something like that… But I

think she - - She thinks she's doing a service by doing this. Yea, like I don't think she knows that we do not talk to her about stuff anymore. But, I don't think she knows how much. It's just that we don't - - we don't really confide in her. You know, she's not really one of my friends, cause I can't trust her. And I can't really confide in her." Brooke

In the theme of *'just do your job,'* nurses viewed the behaviors as disturbing, inappropriate and, in some instances, a waste of time. The issues of gossiping, telling stories, tattling and brown-nosing were grouped together as one theme as representative of the theory of Sense of Injustice. Sense of injustice indicates that the affected nurse interprets an event, action or behavior to be a violation of relative standards or what is considered to be fair norms (Deutsch, 1985; Gurr, 1970; Jost et al., 2004). For these nurses, the injustice is in the time spent with the action or behavior of the other nurse. In Donna's case, it is the stories from home. For Brooke, it is another nurse that watches and tells all, requiring Brooke to always be guarded in her actions and speech. Injustice is a broad category that can also be applied to the later theme of *'you're becoming a threat' – nurses differences and generations,* and how norms are being questioned and attacked due to differences in age and education.

Theme 8: Watch your backside! – Nurses attacking nurses.

Spitefulness, ganging up, and looking for errors—the nurses reported these issues as areas of concern. Nurses attacking nurses was not unusual in the nurses' stories. In the following stories, nurses reported that someone was always watching and analyzing their actions. This type of stress and frustration led to high levels of both passive and

direct conflict interaction. For this reason, these nurses communicated stories that they coined ‘watching my backside’.

Multiple times the nurses expressed the same sentiment: “I can’t trust her (my relief nurse)”. The victim nurse becomes paranoid and is careful to cover all of his/her bases before turning over the shift to the other nurse. They see their relief nurse as mean, spiteful and untrustworthy. Yet, teamwork must continue even though it is dysfunctional, as demonstrated in the following excerpts.

> “I make sure that if she's the one relieving me, I'm all caught up on my charting. So, that really there's no way. There's nothing she could do to make me look bad. And you've got to chart every hour. So, as soon as I get back, I'm putting in 'return from break, dah, dah, dah'. I cover myself. Just because I don't trust her. I don't know that she would undermine me. But, she might leave that IV the whole thirty [30] minutes. And then it could be seen as a 'delay of care' on my part. Because the order was written before I went on my break. I don't know if she would. But, I don't let it.” Jasmine

> “Well, a lot of it is, as we get older, and then you go to the day shift, and you'll get the other ones that come on the night. A lot of us, I mean, they don't stand up for each other. Or, they definitely back bite each other. They go behind. If somebody does something wrong, and stab…. They come in, and I guess they're just bitter.” Helen

> “There’s this classic thing all through Nursing School: ‘Be careful when you get out there because some Nurses are very mean towards new Nurses.’ I think the

majority of Nurses are women. I mean, there are male Nurses, but the majority are women and women, I hate to say it, can be kind of catty, can be sort of gossipy, going behind each other's backs. I think that, that is - - It's really unfortunate because it happens all the time. You'll hear, see someone whispering in the supply cabinet, 'did you see what she did, you know, when she was making that bed over there? Did you see the way she did that?' You know, kinda nit-picky towards each other." Jane T.

"I think [a] majority of conflicts, especially where I work, is if one Nurse is insulting another Nurse's skill level. We're all good at some things; we're all bad at some things. Some Nurses will really attack your weak points just to make themselves feel like they're a better Nurse. Like, they'll constantly be looking for stuff to turn you in for, yeh." Jacob

In the stories told by these nurses, each nurse approached the story openly, empathically and without hesitation. They were not ashamed of the story. They appeared eager and took the position as provider of factual information. Perhaps this position came from horror stories told on the floor of nurses attacking nurses (e.g., Jasmine's story), or from advice offered in nursing school as in Jane's story ('Be careful'). Several nurses told similar stories of back-stabbing, tattling and general attacks. This implied that this type of behavior was not isolated to a few, but rather common for many.

As I constructed this theme, I reviewed nursing literature looking for examples of backbiting, back stabbing and tattling. The information in the nursing journals

concerning these issues was plentiful and listed in multiple topics including: Nurse bullying, intra-professional bullying (Lewis, 2006) and lateral violence and horizontal violence in nursing (Farrell, 2001; Griffin, 2004). These instances, though earlier viewed with the bullying research of Leymann in the 1980s, have been researched by nursing scholars for over 25 years (Farrell, 1997; Roberts, 1983). Griffin (2004), building upon the work of Leymann, Farrell and Roberts, best defines these acts as nurses directing their dissatisfaction toward those less powerful in the same environment with verbal attacks, sabotage, withholding information, undermining activities, backstabbing, infighting, and the breaking of confidence. These actions have been divided in nursing research as overt or covert actions, but of greater significance to the profession is that these actions have been considered a contributor to the nursing shortage, healthcare restructuring, and the shift in nursing roles (Stanley et al., 2007).

In their stories, the nurses did not elaborate on the reason for the lateral violence; however, they did imply that the issue was more interpersonally based than situational, as viewed in the literature. This follows the findings of Hodson (2001) that attacks in the workplace that jeopardizes an employee's dignity involves organizational citizenship, social relations with others at work, and the resistance to unwarranted attacks, abuse, and exploitation by others. Since nurse bullying is a well-documented and researched topic, it continues to be a prime topic for future research, especially in light of the conflict themes identified by the nurses in this study.

Theme 9: I like you…so I'll help! – Nurses and favoritism.

At first glance, it may be confusing why a nurse helping another nurse would be a conflict interaction theme. However, the conflict is not usually between the two nurses but rather with other nurses who are not favored. Similar to the previous section of 'watching your backside', nurses realize favoritism plays a role in getting their work done and done correctly. This is complicated as each of the stories below approaches it from a different direction.

The first story is told by Mary. Mary is an older nurse that selects other nurses to mother, watching out for them and showing favoritism. In her story, she realizes that her statement to the male nurse leans toward a possible conflict; however, she sees the comment as helpful instead of conflict unsupportive.

> "I'm particular what I communicated, I mean, it's not boyfriend-girlfriend, but I like this guy. This guy did good work. And, that, I said, 'hey, John, did you know'? Kind of surprised, 'did you know that what-you-muggier had been on to Airicept?' And he knew and, you know, he just kind of grinned. He didn't say but, that's as far as I carried it…. And yea, I corrected him politely." Mary

Unlike Mary, who was helping a fellow nurse, Jeri stated that she has a nurse that watches her back but, at the same time, will jump in and handle the situation. In the interview, Jeri paused hesitantly and changed her pitch in the final comment about being pushed away. This could be interpreted as embarrassment or even disparagement.

> "…cause I had a pretty rough going as a brand new - - she watched my back. I wasn't getting it right within the - - she push me aside and did it herself." Jeri

Jacob communicated a different impression of the favoritism. Whereas Jeri perhaps appreciated the favoritism, Jacob states that others see the favoritism as a possible plus for him. He sees the conflict that can arise on the horizon.

> "I mean, she really has our backs when it comes down to helping us and she really takes care of our staff. … For the most part, the ones I work with, some think that she picks favorites. I think that's because I have an easy going personality and some other people who all, like, just get along really well and some people don't have that. But some people think that like - - say like me and my DON [director of nursing] are like buddy-buddy, they will feel like that she will be more prone to give me a raise over them, something like that." Jacob

Favoritism can be defined as "the tendency to see one's in-group in more positive terms relative to out-groups" (Chen et al, 1998, p.1490). The concept of favoritism in the workplace based upon membership in a certain group has been explained through the Social Identity Theory of Tajfel (1978). Regarding nurses, the theme of favoritism was difficult to follow. Jacob had the clearest example of a supervising nurse that showed him favoritism in both Jacob's eyes and those of his co-workers. However, later in Jacob's story, he explains that even in the role as 'favorite,' his supervisor would belittle him in front of the other nurses. Jacob explains that, though it is an irritant, he allowed it to happen to offset the favorite status that his coworkers viewed. Subsequently he is viewed as both a symbol of conflict and sympathy. Favoritism was not highly reported

by the nurses; however, most nurses were familiar with a situation in their facility where favoritism was tolerated, but not approved, by the staff nurses, resulting in interpersonal conflict between the staff members.

Theme 10: Some people are just strange! – Nurses not understanding other nurses.

The following statements came from stories in which nurses had conflict with other nurses due to unusual personalities. The lesson learned, as reported by the nurses, was that they tended to get along better with people similar to themselves.

> "She's the only - - the only person that everybody called by her last name. She's the only person I've ever met that everybody called her Miss Hull. So, everybody calls - - everybody had some respect for her, you know. Even though she was the worst Nurse I've ever met, in my whole, entire life, yet, she had been at this hospital since like it opened. So, yea. Well, she would say, 'I was here when it changed from the City Hospital to this, this hospital, and this floor's been' - - I was like, 'this is so weird. And you've been this bad since the thirties [1930's]. This can't be possible'. ….People would always fight with her. She always left at three [3:00], so whoever picked up her patients knew that your day was gonna be really hard, cause she hadn't done anything - - and some people would get mad, and yell at her. But - - she brought in cakes, and stuff. Like, I think, for some reason, I think she was there just to be friends with people, you know. It was kind of crazy" Janice

Similar to Janice who describes Miss Hull as a permanent yet undesirable fixture at the hospital, Jacob tells of a colleague that overdoes the charting. Whereas many nurse 'under-chart', this nurse over-charts stating each event and episode concerning the patient, medical related or not.

> "She's just not real, just absent-minded sometimes. She's not really thinking that what she's writing down will come back. She'll write, she'll Chart about things that have, like, no business whatsoever. Like, I remember one time she was Charting in her Nursing Notes that the patient wanted an apple. Wrote 'I gave them an apple, the apple fell on the floor. Nurse had to go and get the patient another apple, but there was no apple so I gave them a banana. Patient was upset that there was no more apples and didn't want the banana'. All that really! - - well, she just gets hand-diarrhea. And she wonders why we hate to read her notes." Jacob

This conflict theme of *'strange behavior'* was less productive than most themes. The stories told by the nurses usually reflect a difference in personality traits or characteristics, but nothing that seemed unusually eccentric or strange. Jacob and Janice were the only nurses who described the trait of the other nurse as irritating to more than just themselves. In these cases, the strange behavior identified in their stories became a conversation on the floor with other nurses, leading to conflict and a sense of frustration when dealing with the individual.

Theme 11: You're becoming a threat, but I know best! – Nurses differences and generations.

Another conflict theme that surfaced from the nursing interviews is that of differences that emerge due to being from different generations. What is perhaps unique about the nursing conflict interaction is the emphasis that is placed upon one generation being seen as a threat to other generations. The nursing profession has generational threats going both ways—young to old, and old to young. Each nurse's knowledge—knowledge due to experience and tenure, and knowledge due to education and research—becomes a threat to the other generation, leading to a conflict. Because the elements of knowledge and generational differences are intertwined, the title of this section is dual-fold, "You're becoming a threat, but I know best."

The first group of excerpts reflects statements made by nurses concerning other generations within their team or unit. In these instances, the nurses report a level of concern and frustration. In some of the quotations, a sense of uncertainty can be detected.

> "If they are much older or much younger then I think it's almost like a generation-gap. So then there's generational differences … With an older Nurse they learned how to do some procedures, you know, for example, IV starts. How they learned it was old school, they don't all wear gloves, they, you know, cause that's not how they learned so they haven't, they don't do it. And so you just kind of like oh, - - It's just old school, [but] the new Nurses they're still very textbook, very, you know, and they haven't become comfortable in their position as a Nurse

yet, you know - - where you can kind of be open-minded to certain things and they're just kind of very narrow focused because they're brand new. I've said it a couple of times to where I've thought, you know, I hope you're careful. And some will be like 'yeh, I know, and, you know, that's the risk I take' and so I get the sense like no matter what I'm going to say they're still gonna do it their way. … So, I just back off at that point. And the older Nurses like, 'well, this is what I'm going to do.'" Charlotte

"There's a possibility for older Nurses to, not lose interest, but loose the edge that you have when you're first [1st] starting out to want to stay up on things. …some of the older Nurses are a little bit more complacent. But, they sense new Nurses are intimidated, and they're scared, and just they're awful to them. I mean, they yell at them. And, you know, or - - or call them names, and just are very unpleasant." Ashley

"The younger group tends to be a little more immature. …Some of the older Nurses were really good at educating, teaching, showing…And they're saying, they also have like a 'eat your young mentality'… so it was kind of shocking that these older, instead of being just helpful, would actually look for opportunities to 'write you up', or get you in trouble." Sarah

"Some Nurses that have been in my Unit for twenty [20], thirty [30] years and they are full of piss and vinegar and they'll shove a bottle on a baby's mouth and 'drink, drink, drink,' you know. And they don't want to use Evidence Based Practice to change their practice." Karla J.

The quotations presented above come from various age groups of nurses; however, their statement refers to older nurses in the profession. In these statements there is a clear level of dissatisfaction and disrespect for the older nurses. If the reader didn't know, you would assume that the next set of quotations came from older nurses; however, each of these comments was made by the youngest of the nurses interviewed. Some of these nurses have been out of school for less than one year while others have been practicing for two to three years and decided to return back for graduate work while remaining employed by the hospital. In each case, these nurses are referring to their own generation.

> "Younger nurses think the things that they were taught and what they're doing is better and more current than the older nurses." Chelsea

> "And I do think there's an attitude among really young Nurses, that just got out of school. There can be, especially ones that got hired right away. There's a big ego trip that's like, 'well, I, you know', just kind of 'I know everything, and there's not much to learn.'" Jackie

> "…the young nurses, and the new nurses just don't want to pay their dues to get the good shifts and hours. They all want the weekends off…and they expect them off the very first day they start working. I like working with them, but they need to pay their dues." Julie

"Not all of them [younger nurses]. They are very spoiled. Well there's nothing that, if they don't get the month, they don't get the day they want off, they just call in, and we're short." Helen

"But - - I think that sometimes younger people don't have quite as good as a work ethic as older folks, or if it's their very first job ever. I've worked a lot of different jobs. Sometimes if it's their very first job and they don't really know. Kind of, they don't take it as seriously, I guess. They tend to call in sick a little bit more or kinda take longer breaks." Jane T.

Generational conflict was an issue that surfaced continually in the nurses' stories. Since the participants represented all age groups, every age had a comment about their own generation and the others. No single age group surfaced in terms of having greater conflict with another group. Rather, they all had good and bad things to say about each other. One point that was in their stories of differences was that no nurse solely criticized the other generation. In each story, the nurse would criticize or support both groups. Each time a nurse participant would criticize another generation, they would also criticize their own. Therefore, it would be wrong to conclude anything specific regarding in-group or out-group communication based upon the stories in this study; however, the stories did suggest that value and teamwork may play a greater role for the nurses than their generational membership. And, as stated before, many of the theories outlined in the previous conflict themes could be applied to this theme of *'You're becoming a threat'* due to generational differences.

Theme 12: By nature, this is who I am and what we are! – Personalities of nursing.

"The meeting of two personalities is like the contact of two chemical substances; if there is any reaction, both are transformed." Carl Gustav

As quoted above by Carl Gustav, the meeting of any two personalities will create a reaction and, in the cases of nurses, their personalities, characteristics and attributes all work in unison to create an effective caregiver. However, these same attributes, when blended with similar attributes of another nurse, can lead to conflict. Therefore, this final theme identified what is possibly the most obvious concern, the personalities of nurses, detailing how they recognize and confront, or choose not to confront, conflict.

The nurses in the following stories are exhibiting a 'nurse personality' – one that is displayed as uncompromising either consciously or unconsciously. The first set of quotations presents the 'need to be right' personality characteristic. It is from this characteristic that nurses will find it difficult to personalize or individualize their responses to other nurses when involved in a conflict event.

"…the only times I take action is when I know I can win…if I know I can win, I mean, I'll pursue it, yea. But a lot of times, you know, passive, or will take later action." Mary

"I'll give up, needing to be right, even though I will completely explain my point of view. I'll defend myself, but, I also want everyone to be happy." Karla

"…if I feel like I'm not going to be able to win… 'I'll just forget about it.'" Jacob

"I don't know if it's [we're] so defensive, or [we're] so worried of getting in trouble." Jackie

"…it looms over our heads, where we never want to admit if we made a mistake." Jackie

The following quotations may explain why the nurses adhere to an uncompromising personality trait – an atmosphere that appears harsh and competitive.

"So, most nurses are, by nature, anal. I don't know which came first. Like they're anal, and then became nurses. Or they chose this career path, and it made them more anal, and like attentive. It's like the chicken or the egg." Sarah 003

"Nurses have like 'OCD' (obsessive compulsive disorder), it's like we check, and double check, and we just have to be so thorough, cause we deal with people's lives." Sarah

"The old phrase, 'Nurses eat their young'…it's true." Helen

"You have to prove yourself to everyone." Karla

And finally, the most insightful quotation comes from Karla:

"I guess nurse are a 'little' forgiving, there's such high stress that maybe we know that we're gonna fight with each other. Just forgive each other eventually, cause you still need that person to help you." Karla

Summary and Conclusion

Twelve conflict themes were detected from the participants' stories. This section provided the base of narrative evidence to support these conflict themes. As each of these themes surfaced, I was reminded of the conflict themes of Peplau (presented at the beginning of this chapter). These nursing narratives, collected a half-century later,

supported and update her understanding of nursing conflict. The combination of the themes and the matching theories connect the nurses to conflict themes in other work settings, but also shows how the beliefs about nursing influences nurses' sense that their profession is unique.

Chapter Five – Issues across nursing conflict themes

> *The feeling of having no power over people and events is generally unbearable to us – when we feel helpless, we feel miserable. No one wants less power; everyone wants more. In the world today, however, it is dangerous to seem too power hungry, to be overt with your power moves. We have to seem fair and decent. So we need to be subtle – congenial yet cunning, democratic yet devious (Greene, 1998, xvii).*

Introduction

The understanding of power by the individual is instrumental to understanding the actions of others, as well as self (Foucault, 1982). From Greene's statement above, "no one wants less power; everyone wants more," it is both simple and unproblematic to understand why Peplau, in her research and writing, listed power as the first and primary reason for nursing conflict. I opened the results section of nursing conflict themes by citing the list of Peplau's conflict themes: power, safety and stalemate. But I chose not to follow her path of generality in constructing my themes as I believe that generality, due to incorrect conclusions, can lead to misinterpretations and confusion. Peplau was both accurate and logical addressing her research through these generalized conflict themes; however, they become so broad that there is little room for misunderstanding or discussion. Peplau's themes are all-encompassing. These three theme topics from her writing cover substantial ranges of conflict due to the generality:

1. Power – as the sense of control of the situation
2. Safety – as in a sense of security and satisfaction from the situation

3. Stalemate – as in a sense of lack of control and lack of satisfaction from the situation

These are the explanations that resonate through Peplau's research and writings; however, my approach to conflict themes in nursing look not only at power, but at, fittingly, 'the good and the bad'. I started the research seeking stories of conflict and quickly discovered there were fewer stories that the nurse could recount regarding general power or the lack of it. Nursing, as I discovered, is a profession that speaks of subtle power. Nurses take pride in their personal efforts but not necessarily in group or community efforts. This led me to realize that this is a profession that is very self-conscious, self-protective and self-focused. And as they are concerned about themselves, they undoubtedly compare themselves to others and others to them. This surfaced in my initial question of 'why do you like nursing' and 'what makes a good nurse or bad nurse'.

After categorizing and examining the interviews of the participants, I realized three general conclusions, or 'discoveries', as I refer to them. These discoveries are not the conflict themes in answer to the research question. Rather, they provide insights and understandings into the profession—they allowed for, and helped in recognizing, the different conflict themes. Through these discoveries I was able to construct an inclusive list of twelve conflict themes. These conflict themes answer the research question: what communication conflict themes were discerned from the conflict interactions of nurses?

Discoveries

My initial discovery was that the nurses generally described themselves, and others, as: busy, pressured and with limited time. They have to constantly prove themselves to others to earn and maintain respect. This respect is generated by practice

(and experience) but more by education and tenure. From the conflict stories, seniority and placement within the system shows to be critical elements to the profession and affects how nurses regard and act toward each other. Education plays a pivotal role in the nursing world, as well. As more ADNs enter the profession, the greater the divide between the level of breadth of knowledge and skills. But age was also found to play a major factor in the profession. In nursing, age was seen as a major catalyst for conflict and respect. However, the greatest discovery from the profession is the self-protection characteristic that each nurse maintains. The nurses clearly stated that they continually watched out for themselves in order to protect their credentials and licenses.

The second discovery was that all the nurses liked their profession and their career. Basically, they like what they do. They enjoy helping people and watching the healing process. Even more, they like being in the healthcare mix, being part of the actual recovery process and making a significant contribution to the patient's well-being. They all had stories and definitions describing a 'good' nurse. Most, if not all of the time, they were describing their own characteristics and the way they see themselves. And, when asked about a 'problem nurse', nurses could give numerous examples. The 'good' traits—motivated, caring, assertive, vigilant, safe in practice, accurate, organized and seeking best practice—were promptly related to the problem nurse's traits—questionable practice, questionable ethics, lack of knowledge, slacking off, constant mistakes, failure to complete task and general laziness. These problem nurses and their characteristics appeared as the opposite of the good nurse and thus became the catalyst for the identification of the twelve narrative style descriptions created in my list of nursing conflict communication themes.

Lastly, according to some scholars, nurses are intrinsically avoiders of conflict (Baker, 1995; Cavanagh, 1991; Eason & Brown, 1999; Hightower, 1985; Marriner, 1982). Instead, in this study nurses tend toward avoiding confrontation and accommodating others unless it affects ethics, patient care or procedure/best practice. Then nurses become confrontational. If they do avoid in these contexts, they suffer self-doubt. There does not seem to be much middle ground in their approach to conflict with other nurses.

Listed below is a listing of the twelve major conflict communication themes and related theories. Many of these themes closely resemble and are supported by theories identified in the literature.

1. *Since when is it OK? A question of ethics, morals, legality and best practice.*
   Moral-sense theory in ethics and the concept of absolutist and dispositional view (Broad, 1944-45; Firth, 1952).
2. *You really don't know what you're doing! A questioning of training and education.*
   Competence theory and the concept of social comparison (Festinger, 1954).
   Expectation states theory (Berger et al., 1977).
3. *Don't make me come after you! Dealing with slackers.*
   Free ridership theory (Arneson, 1982; Coleman, 1988)
   Resource mobilization theory (Oberschall, 1980).
   Fairness theory (Rawls, 1971; Rabin, 1993).
4. *So what's your problem? Nurses not helping out other nurses.*
   Effort and stigma of helping (Ungar, 1979).
5. *My way or the highway! Know- it-all and not-listening nurses.*

Absolutism (Perry, 1985).

6. *Just don't bother me with that. Nurses disrespecting nurses.*

   'Holier than Thou' (Epley & Dunning, 2000).

7. *Just do your job! Stop brownnosing and wasting my time.*

   Sense of injustice theory (Deutsch, 1985; Gurr, 1970; Jost et al., 2004).

8. *Watch your backside! Nurses attacking nurses.*

   Bullying and mobbing (Leymann, 1990, 1992)

   Horizontal and lateral violence (Farrell, 2001; Griffin, 2004).

   Intra-professional bullying (Lewis, 2006)

   Workplace dignity (Hodson, 2001)

9. *I like you…so I'll help! Nurses and favoritism.*

   Social identity theory (Tajfel, 1978).

   Ingroup – outgroup comparison (Mullen et al., 1992).

   In-group favoritism (Chen et al., 1998).

10. *Some people are just strange! Nurses not understanding other nurses.*

11. *You're becoming a threat, but I know best! Nurses differences and generations.*

    Generations (Mannheim, 1952).

    Outline of a theory of generation (Eyerman & Turner, 1998).

12. *By nature, this is who I am and what we are! Personality of nursing.*

The Conflict Themes

'*Since when is it OK*' was the most interesting of the discovered themes. This theme was recorded the most times with stories that were passionate. This pertained not only to the nurses telling the story, but to the entire profession. The question reverts to their training and mentoring as to what is right and what is wrong – following the concept

of moral-sense. Is it right for the action to occur? Is it fair to all parties? And can I be implicated in a wrongful act?

The nurses explained in their stories that they preferred avoiding conflict and confrontation, preferring to 'give-in' or accommodate. The exception was events involving ethics, best practice (as in safe practice) and when the patient's care was jeopardized. At this point, the nurses become confrontational and combative. Such events occur in the stories told in this theme: 'Since when is it OK'. Some of the stories were surprising and eye-opening—stories such as the unapproved removal of drugs from the Pixus machine, the use of short-cuts in patient care and overmedicating patients to keep them quiet during the night. These actions can place a nurse at risk in addition to placing a patient at risk. But ethics is not isolated to the nursing profession. Bank tellers have been known to take money out of cash drawers for vending machines. Chefs may cut corners in sanitation and food quality. These too are ethical issues; however, they may or may not have a lifelong effect on the individual. But for nurses it is different. As attested by one of the nurses, "just look at the code". Section 301.452 (Grounds for disciplinary action) number 13 of the Texas Nursing Code elaborates on acceptable standards of patient care, unacceptable nursing practice and risk of harm, citing them as grounds for serious disciplinary actions that may result in the temporary or permanent revoking of a license (See Appendix K). Essentially, act unethical and you may lose your license. This is likely why this theme surfaced first and foremost, told in the accounts of the twenty-four nurses. Ethics are important to them.

Similarly, the question of knowledge and education surfaced repeatedly. Knowledge and education became the second theme as reported in '*You really don't know what you're doing'*. This was not a difficult theme to detect and certainly not hard to name. Ethics disturbed the nurses and, in many ways, frightened them. But ignorance simply frustrated them and made them argumentative and generally unpleasant. Considering this theme, I was drawn to the similarity in the concept of shame and guilt. It has been explained that guilt is related to action due to the violation of rules, making guilt usually situational and finite. Contrarily, shame is related to vision and perception with self-understanding and self-presentation, making shame not always situational, but more often all-encompassing because it involves and affects the whole person (Nauta, 2009). Looking back at the conflict themes, ethics could be considered situational; however, knowledge and education is more all-encompassing of the nurse. It affects everything the nurses do, their actions, practice style and decision-making ability. Like shame, knowledge and education may weigh heavier on a person in the nursing profession. Because of the long-term consequences that may be contributed to education and knowledge, nurses reported significant concern regarding their colleague's knowledge and education, or lack of it.

It was clear in the stories that this theme did not relate to the question of 'willful wrongdoing', but rather to a lack of knowledge, poor decision-making and the inability to perform the task successfully. No one wants to trail a person that makes obvious mistakes or commits acts that can cause harm to a patient. As one nurse said, 'do no harm'. But the harm in question did not apply solely to the patient. Again, the nurses reported that they feared personal implication of a wrongful act committed by another

nurse. Once more, their license would be in jeopardy. I began to see a reoccurring concern among nurses that created a common denominator for the themes: 'Don't lose your license', an interdependent guilt risk in the profession.

It was from this theme of lack of knowledge and competence that I began to see a movement in the conflict. Where the predominant focus of scholarly literature had been on personality traits, it now centered on cultural traits, specifically education and training. Apparently, there is an attitude of superiority and inferiority in nursing based upon a person's educational degree and experience. This issue of experience later surfaced in the theme '*You're a threat*', a concern based in generational differences. However, age is not as large an issue in the 'You don't know' section as it is for education. From my field notes, I had a description from nurses that best explained the education/certification concept that some consider and many abide by (see Figure 1).

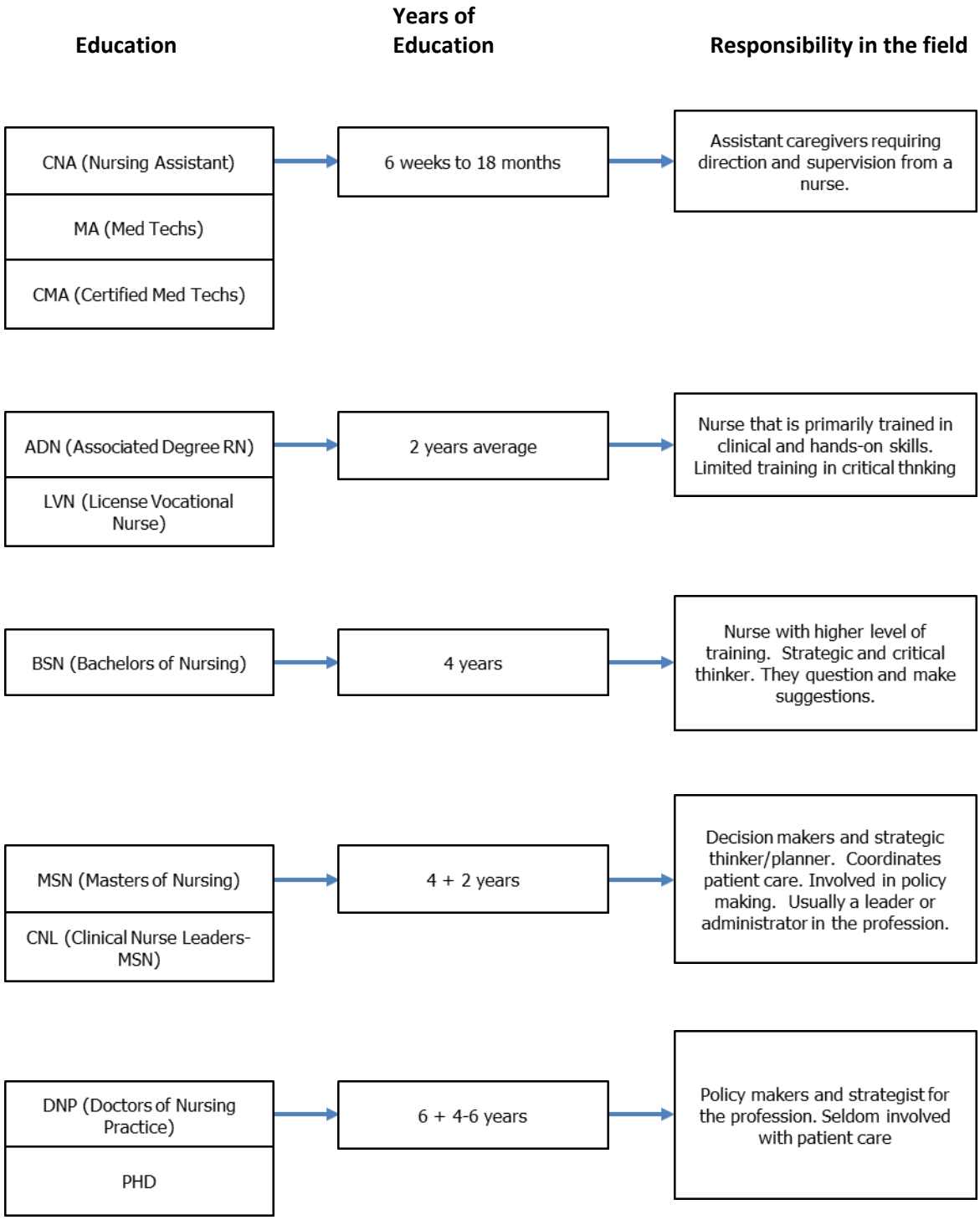


Figure 1. The education/certificate concept of nursing as elaborated by the participants in the healthcare profession.

Upon review of this figure one can see the 'land mines of conflict' that education can place for the nursing profession. Every nurse has a limitation. It is when those limitations are stretched that confrontation occurs. Multiple times, nurses reported in their interview that ADN-RNs should not compare themselves to BSN-RNs or MSN-RNs, and everyone should remember their specific level of training. From Figure 1, the differences become clear in understanding why nurses become frustrated over practice and knowledge. I recall a comment by Donna, "A two year degree … it's kind of a joke - - - we say!" Then there was Juliet as she stated her frustration in the story of a LVN that hung a piggy-back IV below the main bag instead of above. A basic lack of understanding of gravitational pull was Juliet explanation of the LVN's action, noting that the LVN argued with her that the location of the smaller bag was inconsequential to the gravitational drip process. But then there was the statement that ADNs get the job offer over the BSNs because of their 'hands-on' skills. These and other stories created the irrationality and frustration found in the 'You do not know' conflict theme.

The third most told conflict story was that of, '*Don't make me come after you*'. This conflict theme was more than expressed; it was assertively verbalized. The reason for this theme's frequency was probably because it created the most daily frustration for the nurses. 'Dealing with slackers', was a phrase often used by nurses to describe this type of action in their interviews. It would sum up the problem: there are slackers in the profession—nurses who know better—yet they continually leave work undone for the next nurse and get away with it.

Every conflict theme has a reason why it occurs. In the slacker theme, several nurses cited that they heard from the slacker that they were: too busy, tired, just didn't have time, or had a poor attitude due to being overworked. The other concern in 'slackers' is evident in stories provided by Donna and Chelsea. In both cases, they felt a loss of power and control. They felt manipulated by others and, in some cases, felt the offending nurse was not just being a slacker but was taking advantage of them. Patti reported the same issues when stating that she knew the work would not be completed by the night nurse preceding her. She had come to expect it and was used to it not being done. In this theme, the conflict was not over education, experience or age. The nurses interviewed were all faced with similar issues of slackers creating conflict by looking for opportunities to take action or the opportunity to not take any action, depending upon the situation. Therefore, unlike the previous two themes that were primarily based upon a person's personality, morals or knowledge (ethic or ability), I concluded that the 'slacker' theme is a conflict based upon control and power, similar to Peplau's first conflict concept.

In the theme, '*Just do your job',* though appearing to be similar to the slacker theme, this theme surfaced when the actions of one nurse affected the productivity of another. Gossiping, brown-nosing, tattle-telling and bringing stories from 'home to work' were all mentioned. In contrast to the 'Since when is it OK' theme that produced conflict due to right versus wrong, the 'Just do your job' theme moved the conflict to the level of personal job gratification and satisfaction. The nurses report that productivity is important, and any distraction to their busy schedule can lead to personal frustration. This concept could further be explained and supported by the 'slacker' theme and the

'you don't know' theme in that the nurses were impatient with the failure or inability of another nurse. Like other themes listed, this theme of 'just do you job' is prime for further research. Although this theme is relates to the theory of sense of injustice, the attributes can also be the catalyst for professional bullying and insidious workplace behavior between members of the profession.

The nursing interviews revealed a characteristic that I had not foreseen, 'forth-rightfulness' or unassumedly not timid – a sense of absolutism. The nurses had no problem describing areas that frustrated, and simply angered them. '*My way or the highway*', a conflict theme focusing on know-it-all nurses, surfaced repeatedly in the interviews. Of course, no one likes a know-it-all; however, nurses appeared to want to be recognized for their value, expertise and especially their 'mover and shaker' style of getting things done in the best and most efficient way. When their way is blocked, they react and respond strongly with descriptive explanations of the offending nurse: 'She's insecure' (Donna and Sarah), 'she just half listens' (Jacob), 'she doesn't listen' (Kelli), and 'they cannot be told anything' (Jeri). As stated earlier, nurses were seen to avoid and accommodate (Valentine, 2001) unless ethics or best practice was in question. Such is the case with 'my way or the highway' where best practice becomes a question for the nurse and results in a conflict confrontation. This was observed in Donna's story of not changing a procedure when necessary, and Sarah's story of a procedure being changed when it was 'not broken'. These are examples of best practice not being implemented, resulting in a conflict for the nurse.

Supporting *the 'my way'* theme is the '*Don't bother me*' theme of nurses disrespecting each other – a theme similar to the 'Holier than thou' theory. Few stories were told regarding this theme, which would suggest that most nurses do respect others in the profession. However, nursing behavior in the field can take many forms. We have already seen the reaction to knowledge, education and ethics, which becomes a concern for the nurses as it relates to their job performance, their ability to care for the patient and most of all, the protection of their credentials. However, as we look at the themes of *'Don't bother me', 'Watch your backside', 'Some people are strange', 'I like you'* and especially *'You're a threat',* we see nurses working as team players, but very autonomously. They report to support each other if they think you're a good and ethical nurse. Otherwise, they report blocking other's goals, and verbally confronting the offender. Most notably, regarding support or lack of it, is the question of age. Much like the education issue, age, as stated in the 'You're a threat' theme, encompasses both extremes—experience and youth.

An obvious issue with generational difference between nurses was told in thirty different participant stories. Instead of just age, in nursing, age is confounded with training and practice. Young nurses come out of school with knowledge of new methods and practices. Older nurses that feel confident in their role and capabilities protect themselves by questioning new advances. Only nurses who returned for additional education, to get a MSN, embraced and appreciated the new nurses. This was even apparent with older nurses that just graduated from nursing school and had entered the profession for the first time. Though new in knowledge and experience, they were still

not embraced, much like their younger colleagues. This would suggest that age may not be as much of a conflict catalyst as is the issue of experience and tenure.

The older nurses view themselves as still valuable to the profession, even though their knowledge may be less up to date than their younger counterparts. But we cannot discount age in the professional mix. The example of the older nurses not using gloves for a procedure and then being questioned by the younger nurses would imply both a practice issue and an age issue. For years, nurses had not used gloves for certain procedures. Now, the younger nurse arrives at the scene and has been taught to 'glove up' not only as a new practice, but also as a safety issue to prevent the transmission of diseases from infected body fluids. This concern resonates with a population that grew up in the years of HIV and Hepatitis, but not as much for the older nurses. So was their rebuttal to the younger nurse that they would not 'glove up' a direct power play due to practice or generational age? In this case, age likely was a greater contributor to the nurses' decision than perhaps practice. Time and again, older nurses stated, "this is the way we do it". This would imply both a move away from safety to protect their rank and tenure, and a move toward power to avoid intimidation from a younger or newly trained nurse. Therefore, is age solely a contributor to conflict within nursing interaction? The stories from the interview argue both ways—that actual age can have an effect, but seniority and security of self-esteem and position may be greater issues for the older nurses.

There are many stories regarding generational differences. This was not an anomaly, but appeared to be a fact of the profession. A full investigation of age and

experience is beyond the scope of this study. For this research document, however, the disagreements and attitudes provided some insights, but primarily rich face tactics between the two age groups. These face tactics will be discussed in the subsequent chapter; however, as for a conflict theme, power and safety were both seen surfacing in the generational conflict interactions.

Summary

There is a suggestive connection between the research findings of this study and Peplau's three categories of nursing conflict—power, safety and stalemate. Though the twelve identified themes in the current data were based on interactions between nurses rather than between patients and nurses, the stories of nurse conflict supported and advanced Peplau's findings.

The frequency and sequence of the twelve conflict-themes reveal that nurses are deeply concerned with self-protection. The issue was repeatedly addressed in the nurses' stories and can be identified across the conflict themes. Ethics, training and education were identified as critical concerns and the frequency and sequence of the stories suggest a pattern of self-protection, especially as it relates to the preservation of the nurses' credentials. This realization may help to explain a nurse's decision to pursue or avoid a particular conflict in a given circumstance. My preliminary findings suggest this conflict issue is important to the profession and may be worthy of further research.

Chapter Six: Face saving tactics in nursing conflict

Overview

In the previous section, a listing of 94 nursing conflict stories yielded twelve conflict themes. Using these themes as a basis for analyzing the nurses' interactions and stories, the next stage of the research was to analyze these stories in terms of the tactics identified in research on face, as listed in Table 2.3 and extended in Appendix O. Then, I reviewed the data searching for patterns, trends and insights into nursing conflict styles. Face tactics have the unique attribute of enabling parties to create a new or revised identity within an interaction (Shimanoff, 1985). Therefore, as an individual attempts to save face by defensive posturing or restorative posturing, face is no longer considered the *objective* of the interaction, it now becomes the *condition* for the interaction (Goffman, 1955), leading to the situation's resolution or lack of resolution. How did face tactics work in the conflicts recounted by the nurse participants?

Having identified 85 face tactics from the literature (as displayed in Table 2.3), I identified each tactic in a nursing conflict interaction. The 85 tactics did not account for all faces moves. I inductively discovered eleven face tactics that were not observed in the literature. I then added these eleven new face tactics to the 85 original tactics to form a new, extended listing of 96 face tactics (displayed in Appendix O). I kept the distinction between defensive and restorative face tactics because it is so prominent in the literature. The eleven new face tactics were as follows:

1. Defensive – Competitive – Halting statement
2. Defensive – Competitive –Enlisting disclaimers –Soliciting others (or appeal to authority)

3. Defensive – Competitive –Blocking goals – Opposite and oppositional
4. Defensive – Competitive – Competitive acts – Taking credit and self-appreciation:
5. Defensive – Competitive –Response – Un-demonizing
6. Defensive – Competitive –Responses – Returning question or statement
7. Defensive – Enlisting Politeness – Sarcastic Politeness
8. Restorative – Accommodative – Accustom or understanding other.
9. Restorative – Accommodative - Apologies – Unconditional
10. Restorative – Compromise – Sidetracking with alternatives
11. Restorative – Collaborate – Accounts – Storytelling and analogies

A listing of the excerpts supporting these new face tactics is displayed in Appendix L. Some of the quotations supporting the new face tactics in the appendix may appear ambiguous and non-specific to the new face tactic; however, an enlarged context would support the analysis. If I could not identify a known face tactic, I sought to construct one that would match the excerpt. Each tactic forced me to reevaluate and re-research the literature looking for evidence that an appropriate face tactic had previously been defined. When my search was exhausted, the new face tactic was formulated, categorized and explained. See Appendix O for the details.

Conflict Themes and Face Tactics

Chapter 4 presented twelve themes that were identified by the nurses' stories of conflict interaction. Of these twelve themes, four were considered robust, often repeated

in the 94 stories of conflict told by the nurses. I used these themes to organize the face tactic analysis. These themes are:

A. Since when is it OK? A question of ethics, morals, legality and best practice.

B. You really don't know what you're doing! A questioning of training and education.

C. Don't make me come after you! Dealing with slackers.

D. You're becoming a threat, but I know best! Nurses differences and generations.

Stories were told with specific face tactics that could be identified according to the listing of 96 face tactics displayed in Appendix O. The process of identifying the face tactics was accomplished systematically by comparing the nurse's excerpt to the listing in Appendix O. As an example, Jane tells a story concerning ethics and the Pixus machine. I identified five exchanges in her story that display face tactics. The lines that display face tactics have been bolded and underlined within the excerpt. At the end of each such line is the code number that identifies the face tactic from the listing in Appendix O, e.g., FT-35 is justification, a defensive competitive response tactic identified by Cupach & Metts 1994.

Face Tactic Story – Excerpt 1

"There was kind of a line to get into the Pixus cause it was busy. I heard the woman [nurse] ahead of me go 'what the hell are you doing', and I guess she, I couldn't really see exactly what was going on, but apparently a Nurse took a Tylenol, some regular Tylenol, and then popped it in her mouth and had a little glass of water. The sink's right there. And then took the rest of the meds out for

her patient, and the little cup and everything. The Nurse said **'I've got a headache. I'm taking a Tylenol (FT-35). Butt out, leave me alone' (FT-14).** And the other Nurse is like **'you can't do that (FT-24), that's under the patient's name. They're being charged for it' (FT-68).** You can't take it, we have our own Tylenol. Like, at the Nurses' station you can take, you're not supposed to take it out of the Pixus. She said **'I don't have time to go to the Nurses' station to get a Tylenol and come back' (FT-67).** I was watching that and thinking.

I used a decision tree, displayed in Appendix M and N, to identify the 96 face tactics in the stories. Any face tactic that is numbered below 50 (<FT-50) in Appendix O is a defensive tactic. Listed below is the explanation of the categories of the specific face tactics identified in the Pixus text.

FT- 35: Defensive – Competitive – Responses – Justification

FT- 14: Defensive – Competitive – Resisting intimidation

FT- 24: Defensive – C2ompetitive – Blocking goals – Blocking opponent's goals

FT- 68: Restorative – Competitive – Accounts – Justification – Appeal to value, logic and reason

FT- 67: Restorative – Competitive – Accounts – Justification – Appeal to utilitarianism

The purpose of this analysis will become apparent later in this chapter as excerpts and face tactics are identified.

Procedure

"She said 'I don't have time to go to the Nurses' station to get a Tylenol and come back.'" (Excerpted told by Jane.)

Each face tactic, as numbered in Appendix O, falls within one of two macro-level categories, defensive or restorative, derived from the theorist that originally identified and defined the face tactic in the literature. These two macro-level categories are significant in face tactics as either a defensive gesture – to protect face, or a restorative gesture to correct the position of face. I discovered early in my research that, while there is an abundance of scholarly face tactics, no organized arrangement of these tactics exists beyond the macro level. Based upon the observation of Graneheim and Lundman (2004), the use of theme, category, sub-category and codes (explanation or examples) provides an effective process to identify narrative meanings. Although Graneheim and Lundman are notable content-analysis researchers in the nursing profession, I elected not to follow their method of content analysis through coding. Instead, I chose a forthright process of identifying face tactics in the text. In this process, I found the Blake and Mouton conflict-management styles to be an effective device to form sub-categories on the macro-level, and also as a means of categorizing the multiple face tactics. I used these styles—competitive, collaborate, compromise, accommodate and avoid—in identifying the categories for each of the face tactics in Appendix O. This categorization was added to the original presentation of face tactics in Table 2.3.

To analyze the excerpts from the stories and select the face tactic that I consider best matches the interaction, I created a simplified version of a decision tree (displayed in Appendix M and N). This tree was created by listing all 96 tactics, branching them back

to the conflict management style I assigned by means of Blake and Mouton, and, finally branching the conflict management style back to the macro-level category (defensive or restorative) originally defined by the author. The purpose of the tree was to provide a means for searching and reviewing all face tactics in a single view, identifying the most appropriate face tactic to the text from each nurse. These classifications and categories would become relevant in the process of analyzing the use of various face tactics and the identification of trends and patterns in their usage.

To test my procedure, two other scholars in communication were asked to identify the face tactics listed in Appendix O to key excerpts from multiple stories. There was complete agreement on my identification of tactics at the level of defensive/restorative and at the five major conflict-style management categories. When they identified different face tactics at a deeper level, it was because the data matched multiple face tactics. Since these were reasonable interpretations, I included multiple face explanations in my analysis. This decision was based upon the research of Van Kleeck, Maxwell and Gunter (1985) that showed how multiple codes for interaction will create a truer picture than single codes.

Example

"She said 'I don't have time to go to the Nurses' station to get a Tylenol and come back.'"

Appeal to utilitarianism – Accounts Justification – Competitive – Restorative

Senim and Manstead (1983) identified a face tactic they referred to as *Appeal to Utilitarianism* (the benefit outweighed the harm). Senim and Manstead consider this

tactic to be a means of justification for an action. They further consider this 'justification' as an 'account' and categorized the tactic as a restorative tactic (instead of a defensive tactic). It also fits in Blake and Mouton's *competitive* style. Below is the display that appears in Appendix O.

Restorative (Corrective) Practices	Explanation Example	Reference
COMPETITIVE		
67. Account – Justification – Appeal to Utilitarianism	"The benefit outweighed the harm"	Semin and Manstead, 1983

Most Common Face Tactics

All of the stories from the nursing interviews were analyzed to identify the face tactics. From the 94 conflict stories matched to the 96 face tactics listed in Appendix O, a listing of the most frequently used face tactics was developed, reflecting fourteen primary face tactics. The fourteen face tactics, displayed below, were repeated at least twice throughout the various conflict stories and interactions. These face tactics are ranked in order of frequency of use. Below each face tactic is an excerpt which bests exemplifies face tactic. These represent only a few of the many lines displaying these face tactics.

1. Defensive – Avoidance – Avoiding the topic (FT-1)

   "….and she wouldn't make a decision on anything, even smallest insignificant - - [she would say] 'I just can't make that decision on my own.'" Janet

2. Defensive – Competitive –Responses – Justification (FT-35)

"I've got a headache. I'm taking a Tylenol [removing medication from the Pixus]." *Jane*

3. Defensive – Competitive –Competitive act – Presumptive remark (FT-32)

   "I like you as a friend, but I don't like you at work!" Jackie

4. Restorative – Accommodative – Desire for harmony (FT-70)

   "I want everybody to be happy, and look good." Ashley

5. Restorative – Competitive –Accounts – Justification – Appeal to Value (FT-68)

   "And I said, 'well, this is not right –this is not a good decision. This woman is a drug addict.'" Juliet

6. Defensive – Competitive –Uncooperative behavior (FT-26)

   "And I said, 'well, I'm not going to give it. That's not – that's dangerous. And if you want to have someone else give it, you can. But I'm not gonna give it.'" Juliet

   Defensive – Competitive –Competitive act – Denial (FT-31)

   "You know, people like, 'oh, no, no, that wasn't me'". Jackie

7. Defensive – Competitive –Returning or shifting blame on others (FT-34)

   "She kind of wanted to know everybody's business and what everybody kind of did. She would say 'Ann did it'. She was going around telling everybody." Abigail

8. Defensive – Competitive –Enlisting disclaimers – Credentialing and soliciting others (FT-17)

   "I'm bad like for my passive-aggressive way, because I'll go…I'll probably call the Rank Nurse." Helen

9. Defensive – Avoidance - Responses – Affective state (FT-5)

   "And I felt like 'why don't you just leave me alone.' They were rude all the time and I think they made me cry several times." Janice

10. Defensive – Avoidance - Withdrawal – Negotiated farewell (FT-13)

"And then, I'm like, 'Whatever. I'll just do it. I'll just figure out a way.'" Helen

11. Restorative – Compromising – Appeal to fairness and Trade-offs (FT-76)

"I mean, compromise by give and take." Mary

12. Restorative – Collaborative – Analytic remarks – Solicitation of disclosure (FT-86)

"And I'm like, 'yeh' and I'm like, 'and I don't have a Masters Degree.'" Kathy

13. Restorative – Collaborative – Conciliatory remarks – Supportive remarks (FT-81)

"I backed off…because she was getting a little angry about it. But, like maybe I was making the situation better by saying, 'no, I do. I understand what you're saying, I do.'" Chelsea

14. Restorative – Collaborative – Agreement or acceptance (FT-80)

"If I'm at fault, I'm gonna take the blame. Just apologize and say it's my fault." Juliet

This listing was created by two methods. The first method was by a running count of the most used face tactics in the nursing interactions. The second method was derived from the creation of a visual summary (see Appendix P for example and explanation) of all the interactions within each conflict theme. This visual summary was created to provide a display to help identify trends and patterns.

In the stories told by the nurses, fourteen face tactics were identified more than twice. Of these fourteen, five were detected four or more times and represent the primary pattern of the nurses when encountering another nurse during a workplace conflict interaction. These face tactics are as follows:

1. Defensive – Avoidance – Avoiding the topic ('I just don't have time for it'): stated nine times
2. Defensive – Competitive –Responses – Justification ('confront and justify'): stated six times
3. Defensive – Competitive –Competitive act – Presumptive remark ('combative remarks'): stated six times
4. Restorative – Accommodative – Desire for harmony ('keeping people happy'): stated four times
5. Restorative – Competitive – Accounts – Justification – Appeal to Value ('the best interest of the patient and practice comes first'): stated four times.

The Relations between Face Tactics to Conflict Themes

The next step was to look for patterns of face tactics grouped by conflict themes. The four most frequent conflict themes from the nursing interactions were:

1. Since when is it OK? A question of ethics, morals, legality and best practice.
2. You really don't know what you're doing! A questioning of training and education.
3. Don't make me come after you! Dealing with slackers.
4. You're becoming a threat, but I know best! Nurses differences and generations.

Each of these conflict themes reflects a select group of face tactics that created trends and patterns.

Facework: Since when it is OK to do that?

From the 94 stories told by the nurses, I found eight defined-situations where face acts surfaced regarding the issue of ethics. Each of these eight addressed a different

ethical situation. I discovered that, not only are face tactics involved in ethical interactions, certain face tactics repeat within different situations. This would imply that nurses reach for similar face tactics when they are the questioning nurse as well as the offending nurse.

It has been previously noted that when ethics are an issue, nurses become confrontational. Nowhere is this more evident than in face tactics related to ethics. Of the stories told concerning ethics, nurses approach the situation in a defensive-competitive manner instead of a restorative stance. The face tactic of blocking the other's goal is the most common of the face tactics used, with presumptive remarks, justification and hostile statements coming in a very close second. This analytical insight suggests that the nurses see the issue of ethics as a major threat to the profession and their individual practice resulting in their aggressive choice of defensive face tactics.

Jane, in her Pixus story, gave us the classic blocking response when the questioning nurse uses the phrase, "you can't do that!" when talking to the offending nurse. However, even with the confrontation face-tactic of blocking one's goals, the face response from the offending nurse does not always follow the usual face response of defensive-competitiveness. Some offenders will retreat and respond using a restorative face, specifically the justification face tactic, claiming appeal to utilitarianism (the benefit outweighs the harm). When this occurs, in these stories the interaction is over. There is no more response from the questioning nurse. The reason for this behavior is unclear except that an aggressive defense from the offender did not occur and, subsequently the questioning nurse saw no reason to pursue the cause. The data also revealed that the offending nurse does not convince the questioning nurse of the acceptability of the ethic

issue. Rather, the questioning nurse's lack of continuance implies that she has made the point and will now move on. But things change when the offending nurse responds in a defensive-competitive mode using defensive justification and disclaimers such as hedging, cognitive disclaimers and refusal/denial. In those cases, the questioning nurse almost always continues the attack using the competitive face tactic of rejection and presumptive remarks such as "I don't trust her. I have no use for her," (Janet's story of an absent team member). Seldom does the questioning nurse retreat in an avoidance stance but, instead, continues the interaction competitively.

These conflict interactions about ethics were generally brief interactions. The nurses show themselves to be blunt, to the point, and no nonsense in their responses. The back-and-forth responses were usually minimal in number and I did not record any story where the participants responded more than twice to each other. Usually, the nurse only responded once to the offending nurse with the offending nurse making only one rebuttal. At this point, the ethics interaction was over. Once it was rejected by the questioning nurse, the offending nurse usually avoided further discussion (of course it should be kept in mind that these are stories told by the questioning nurse).

An analysis of face tactics in this conflict theme would suggest that nurses will confront ethics in a defensive and competitive manner. When confronted with an ethical issue of practice or patient care, the nurses' face tactics are usually at the highest level of confrontation: blocking of the others goals and the use of competitive acts such as presumptive remarks and hostile statements. At the same time, the questioning nurse may attempt to salvage the relationship and guide the offending nurse by blending a

restorative-competitive-justifiable statement such as an appeal to value and logic: "you may have thought it was the right thing to do." This would lead us to consider that nurses, when confronted with an ethical issue, do not always 'discount' the offending nurse as a 'problem' or 'bad' nurse but, instead, may forgive the offender in an attempt to provide a mechanism for the offending nurse to save face. Multiple times, when the justification-appeal to value was presented by the questioning nurse, the response from the offending nurse would reflect the face tactic of utilitarianism, "the benefit or need outweighs the harm." This was apparent in the Pixus story, told by Jane, of the nurse claiming busyness as the reason why she could not walk down to the nurses' station to get a personal Tylenol. This was also evident in Brooke's story of the charge nurse that released a feverish patient prematurely to make room for another patient. In both stories, the offending nurse rationalized her action based upon personal insight into the problem. They do not see their decision as unethical, but rather as logical.

In summary, ethical questions may cause people to justify their actions and decisions. At the same time, they will cause ignited protests from individuals who feel their own ethics and morals (and standing) are in jeopardy. From the nurses' face tactics, we see nurses questioning another's ethics in a confrontational manner but then attempting to provide the avenue for face saving for both parties. It is at that point that the offending nurses either accepts the offer by means of restorative-justification (usually through the appeal to utilitarianism), or denies and combats the other's face by maintaining their own face in a defensive and competitive mode of facework.

Therefore, in general, Conflict Theme #1 (Ethics) relates to face tactics:

1. Since when it is OK to do that?
FT-24 (Blocking)
FT-27 (Hostile remarks)
FT-35 (Justification)
FT-32 (Presumptive remarks)
FT-67 (Utilitarianism)

Specifically, if the offending nurse uses FT-67 (Utilitarianism), the interaction is over. If the offending nurse uses FT-35 (Justification), FT-16 (Hedging), FT-19 (Cognitive disclaimers), or FT-36 (Denial), the questioning nurse responds either defensively with FT-32 (Presumptive remarks) or FT-24 (Blocking), or responds restoratively with FT-68 (Appeal to value). This will end the interaction, or moves to FT-67 (Utilitarianism).

Offending nurse	**then**	**Questioning nurse**	**then**	**Offending nurse**
FT-67 (Utilitarianism)	→	No response		
FT-35 (Justification) FT-16 (Hedging) FT-19 (Cognitive disclaimer) FT-36 (Denial)	→	FT-32 (Presumptive remarks) FT-24 (Blocking) FT-68 (Appeal to Value)	→	FT-67 (Utilitarianism)

Facework: You really don't know what you are doing!

Similar to the ethics issue is the practice method, training and education issue. The face tactics used varied from story to story but maintain a common theme of justification in the offending nurse's response. This conflict theme showed five conflict-interactions regarding concern over the knowledge or practice of another nurse. The

longest interaction had seven comments; however, two interactions never made it past the initial rebuttal, with avoidance as a major factor in this conflict theme.

How do people respond when their knowledge or ability is questioned by another? Some respond by confronting the attack. However, in nursing, this characteristic was recorded differently when one nurse questioned another's knowledge or ability. Nurses were observed to show a less competitive or confrontational defensive face within the dispute, but rather a defensive face of avoiding by way of withdrawal, topic management, evasive remarks and general fleeing. Though there are many such examples, they are similar in their approaches. Whereas some interactions, such as those of ethics, only create a couple of responses, the interactions regarding knowledge and practice often drew as many as five rebuttals from the nurses. This is evident in cases where the offending nurse initially responds in an avoidance stance leading the questioning nurse to press the issue in a defensive and competitive face. However, similar to the ethical face theme, the questioning nurse with the defensive-competitive response will later incorporate restoration. This restoration remains competitive but includes an appeal to value, for instance, "this is what's gonna help the group to work better" as told in the narrative by Brooke.

In this conflict theme, avoidance is a major factor. If the offending nurse does not succeed the first time by avoiding the attack on knowledge and ability, it will continue. The questioning nurse will then project a defensive face that blocks the action of the offending nurse. Again, questioning nurses are shown as confrontational when it affects best practice and safety. Unless nurses see a harm or ethical issue, they move toward avoidance measures as a response. Apparently, nurses who see no harm or ethical

question in their action see no reason to confront the questioning nurse. Avoidance seems to be the face tactic of choice—'why should I argue with them?' Apparently, the lesser the skills, ability or knowledge, the less likely one is to defend one's practice and the greater is the emphasis placed on avoiding the entire issue.

Therefore in general, Conflict Theme #2 (Knowledge) relates to face tactics:

2. You really don't know what you're doing!
FT-1 (Avoiding topic)
FT-68 (Appeal to value)
FT-35 (Justification)
FT-32 (Presumptive remarks)
FT-24 (Blocking)

Specifically, if the questioning nurse uses FT-32 (Presumptive remarks), FT-27 (Hostile statements) or FT-24 (Blocking), the offending nurse uses FT-1 (Avoiding topic), FT-35 (Justification), FT-2 (Evasive remarks), FT-12 (Withdrawal - fading), or FT-13 (Withdrawal - farewell). At this juncture, the questioning nurse responds with the restorative FT-68 (Appeal to value) in attempt to repair the situation.

Questioning nurse	**then**	**Offending nurse**	**then**	**Questioning nurse**
FT-32 (Presumptive)		FT-1 (Avoiding topic)		FT-68 (Appeal to Value)
FT-27 (Hostile stmt.)		FT-35 (Justification)		
		FT-2 (Evasive remarks)		
FT-24 (Blocking)		FT-12 (Withdrawal - fading)		
		FT-13 (Withdrawal - farewell)		

Facework: Don't make me come after you!

A recurring conflict theme was the interaction regarding nurses not completing an assigned task, forcing another nurse to either locate the offending nurse or complete the task themselves. This theme produced seven responses from the interviewed nurses and the greatest number of face-tactics. As before, we see that patterns of face tactics begin to emerge. Avoidance tactics are frequent in these interactions, as is the use of extreme comments and justification as an appeal to value.

These interactions start with a questioning nurse asking why a function did not occur, and the offending nurse, the "slacker," responds with a defensive-competitive face tactic. Returning questions, blocking goals, using put-downs, hedging, and returning blame were all recorded as responses from the offending nurses. Secondly, and heavily used by the offending nurse, was the defensive-avoidance face tactic of withdrawal and pretending not to notice. The competitive face tactics were not a surprise in the participant's interactions. People traditionally respond aggressively when questioned about 'where were you' or 'why didn't you perform the task'. What was observed with these nurses was that, in four of the seven interactions, the offending nurse did not respond through a competitive face tactic but rather responded by avoiding the situation. Their defensive face tactic is that of withdrawal or pretending not to notice, a tactic that draws a wide range of face tactic responses from the questioning nurse. Again, it should be noted that this face action supports the claim that nurses are both avoiders and accommodators by nature (Valentine, 2001).

In this 'slacker' conflict interaction, accommodating is not a face tactic used by the offending nurse, but rather the avoidance. For the questioning nurse, avoidance on

the part of the offending nurse does not define any set pattern in her own face response. The questioning nurse is seen to continue in the defensive-competitive face tactic of responses: credentialing; blocking goals; and competitive responses of truth, as in Mary's, "[I had to] get proof" that the offending nurse was not doing her work. Other examples include the use of blocking the opponent's goals, as Jeri demonstrated in her statement that "[I] raised up my hands like 'hello'. Like 'wake-up'", signifying her exasperation with the offending nurse who did not understand Jenny's frustration for the lack of charting. However, for several of the offending nurse's avoidance responses, the questioning nurse moved toward a restorative face tactic signifying the desire to express disapproval for the slacking, but also to maintain a positive relationship with the nurse. In these interactions, the questioning nurse primarily uses the restorative face tactic, but includes competitive justification by means of appeal to value and logic. Mary gives a classic response using appeal to value as she tells the offending nurse, "hey, you know what-a-mijiger [patient] would want to have been changed?" [Referring to his bandage.]

In three of the seven stories, the nurse responded in this competitive-restorative stance by claiming appeal to value as in, "this is the right thing to do." This justification, though competitive, is frequently used by the questioning, upset nurse, to restore her face while simultaneously confronting the offending nurse. Would there be a rationale for this face-tactic behavior? Likely, since these nurses must work together as coworkers and depend on each other. We must remember that one nurse might be on a day-shift reporting to the night nurse, but that same night nurse will report back to a day nurse within twelve hours. Often, it may be to the same day nurse that reported to her earlier. It has been stated before that this is a reduced teamwork profession; however, when patient

care and best practice is at stake, accountability appears to become paramount. I never heard from any of the participants that a slacker nurse abused or mistreated a patient as a means of benefitting or exploiting another nurse. Instead, the nurse selectively uses defensive and competitive blocking mechanisms to get her way by not completing a task or function.

Consider Mary's story of a nurse that refuses to change a bandage before a shift change. She said (in the story), "I'm busy". A response like that from the offending nurse was in response to the questioning nurse's defensive-competitive, or restorative-competitive stance. This usually occurred near the conclusion of the interaction. Again, there was no set pattern in the offending nurse's face tactic response. In some cases, the response is that of restorative apology or acceptance, as in Donna's story when Frankie said, "Okay, yea, I can see what you're talking about, yea, I didn't really realize [I didn't chart]". But just as many responses were that of defensive-competitive denial, as in Lucille's "I didn't know you did that," response in Kathy's story. Perhaps more stories would reveal pattern of response to any specific provoking face-tactic by the questioning nurse, but there was none in the stories told. There may be other aspects of the situation more influential.

In summary, nurses will use blocking and competitive acts to neglect work when it comes to interacting with another nurse. What surfaced significantly is that the oncoming nurse (the questioning nurse) handles the conflict situation in a manner of justification, appeal for the value of the situation, profession and the patient. Following this approach, the offending nurse, though starting in a competitive or avoidance stance,

will ultimately respond in a restorative mode to save face but, by using denial of intent ("I didn't mean to do it") as a response.

Therefore in general, Conflict Theme #3 (Slacker) relates to face tactics:

3. Don't make me come after you!
FT-1 (Avoiding topic)
FT-68 (Appeal to value)
FT-35 (Justification)
FT-17 (Credentialing)
FT-24 (Blocking)
FT-22 (Extreme comments)
FT-91 (Denial)

Specifically, if the offending nurse uses FT-1 (Avoiding topic), FT-35 (Justification), or FT-22 (Extreme comments), the questioning nurse uses defensive FT-24 (Blocking), FT-17 (Credentialing) or restorative FT-68 (Appeal to value). The restorative is used in an effort to repair the situation. At this point the offending nurse responds with restorative FT-72 (Apology) or FT-91 (Denial).

Offending nurse	**then**	**Questioning nurse then**		**Offending nurse**
FT-1 (Avoiding topic) FT-35 (Justification) FT-22 (Extreme Comments)	→	FT-24 (Blocking) FT-17 (Credentialing) FT-68 (Appeal to Value)	→	FT-72 (Apology) FT-91 (Denial)

Facework: You're becoming a threat. Differences and generations

Several face tactics are used in the interactions as nurses encounter generational differences on their shifts. A combination of credentialing, labeling, and putting down

are seen associated with this conflict theme. In the stories, many of the face tactics are used differently depending upon either the desire to defend face to the other generation; or to restore face as a means of restoring a positive working-relationship. In both instances, the nurses tend to go back and forth between defensive and restorative tactics.

The stories from this theme are rich and the tactics are fascinating. While there are only eight generationally driven stories of conflict, they reveal the fear and concern nurses have for keeping their jobs, whether they are an older nurse, or a new and/or younger nurse, they all feel the need to prove their value to others.

The most detailed and lengthy interaction comes from Karla. She was a new nurse but not a young nurse. She had previously worked in a doctor's office in a role as office manager and assistant to the physician, a plastic surgeon. Unlike many hospital nurses, Karla had firsthand experience learning from a doctor who taught her how to maximize productivity and still set priorities for the benefit of the patient. When Karla encountered an older preceptor-nurse in the hospital, they began to butt heads. Karla used the restorative face tactic of appeal to value and logic, a competitive mode, but one that was compromising and accommodating. I observed in the interviews no use of appealing to value by younger nurses. Perhaps they do not have the knowledge to question the norm or what is best for the patient. Alternatively, younger nurses may have knowledge of new and improved practice procedures unknown to the older nurses. In the stories new young-nurses did not directly defy seniority by questioning a procedure of the older nurse. This typically would occur through the charge nurse, an interaction that was seen in the interviews. A new young-nurse does apparently feel right about appealing to fairness, face protecting, and making social comparisons. Karla's comment, "I think it's

because I'm new – it's all because I'm new" shows her view of her status. Karla's story is full of defensive and restorative face tactics but most are competitive credentialing, returning questions and statements, put-downs, holding for suspended judgment, claims of misrepresentation, and lots of justification. Karla's encounter is especially varied, but comparing it to the other age-interactions, we see many of the same face tactics.

Can we make any firm conclusions based upon the generational stories? Likely not, since there were a limited number of stories told regarding generational face tactics; however, the stories did provide information that would suggest a need for future research into generational conflict and face tactics. These stories can help to explain and produce insights into the difference between the nursing generations and how they incorporate certain face tactics when confronting the other generations, specifically, regarding teamwork and respect.

Regarding teamwork, there is no clear pattern of either old or young nurses using restorative face tactics. Apologies, accommodation, or collaboration does not surface in one more than the other, and it hardly surfaces at all. This relates back to the earlier statement that most nurses are self-focused, self-protecting and generally autonomous in their work habits. Even with different generations of nurses, teamwork most likely occurs; however, as this study was based upon conflict interactions, the nurses told few stories of happy, teamwork interactions. However, as blocking and hostile remarks are the nemesis to teamwork, so is the face tactic of avoidance. In the generational difference of nurses, avoidance and withdrawal occurs almost exclusively within the population of younger nurses. Avoidance is considered by most scholars (Cupach &

Metts, Semin & Manstead, Argyle et al, Ting-Toomey) as a restorative face-tactic. Therefore, as seen in the stories of generational conflict interactions, both age-groups use competitive face tactics to protect their ability, personality, training and experience. The young nurses told stories of older nurses using put-downs and hostile remarks in a defensive mode, while the older nurses tell of younger nurses using competitive tactics as appeal to face, fairness, social comparisons and, sometimes, value and logic. Avoidance as a face tactic is seldom used by older nurses but frequently incorporated by the younger nurses to restore or save face.

From the stories told, I did not gather in the nursing profession that it is an old against the young situation. However, from review of the generational stories, it does appear that the older nurses spend more time protecting their face, their value and their knowledge from the younger nurses, while the younger nurses spend their energy proving their value and worth—as holders of new and relevant knowledge. In this study the younger nurses tell stories that show they are entering a profession where they are not respected for their knowledge, while older nurses feel they are being pushed out due to lack of respect for their years of experience. It was from studying the face tactics in the interactions that this insight became apparent.

Therefore in general, Conflict Theme #4 (Generations) relates to face tactics:

4. You're becoming a threat!
FT-17 (Credentialing)
FT-68/69/76 (Appeal to value/face/fairness)
FT-20 (Suspended judgment)
FT-12 (Withdrawal-fading away)
FT-24 (Blocking)
FT-58 (Personal idiom-labeling)
FT-64 (Social Comparison)

Specifically, when the younger nurse feels threatened, the usual response is defensive using FT-20 (Suspended judgment), FT-12 (Withdrawal-fading away), and FT-17 (Credentialing – as in this is the new way). The older nurse responds defensively to the younger nurse with the FT-17 (Credentialing – as in I've been here longer) or restoratively with FT-58 (Personal idiom-labeling). If the older nurse initiates the interaction due to feeling threatened, the older nurse uses FT- 24 (Blocking goals), FT-17 (Credentialing) and occasionally FT-23 (Put-downs). The younger nurse was seen to respond restoratively to the older nurse's defensive posture with FT-76/69/68 (Appeal to value/face/fairness) and FT-68 (Appeal to social comparison).

Younger nurse	**to**	**Older nurse**
FT-20 (Suspended judgment) FT-12 (Withdrawal) FT-17 (Credentialing)		FT-17 (Credentialing) FT-58 (Personal Idiom-labeling)

Older nurse	to	Younger nurse
FT-24 (Blocking) FT-23 (Put-downs) FT-17 (Credentialing)	⇒	FT-76/69/68 (Appeal to value/face/fairness) FT-64 (Appeal to social comparison)

Summary and Conclusion

Identifying face tactics within the conflict stories' proved to be a challenging endeavor. The nurses in the conflict interaction displayed a broad range of face-tactics from the literature, using them in all facets of the conflict from defending face to restoring lost or damaged face. At the same time, the identification of face tactics to conflict interactions did reveal patterns in the face tactics. Patterns of face tactics emerged and were associated with specific conflict themes. Therefore, face tactic patterns can be detected. Certain face tactics surface within specific conflict-themes. These same face tactics can elicit a group of specific, responding face-tactics from the other party. The impact of such patterned face-tactics opens new opportunities to explore the power that face can play in conflict interaction. These opportunities will be discussed in detail in the next chapters.

Chapter Seven: The discussion of face tactics within conflict themes

"It is not our abilities that define our personality, it is our choices."

Author unknown

Introduction

To best understand how face tactics contribute to conflict management, I return to my earlier observation that conflict tactics, according to Wilmot and Hocker (1998), provide us different levels of engagement or avoidance of a conflict. When engaging in a conflict, we understand that the ability to defend face (as a defensive move) or restore face (as a restorative move) plays a critical role in how we move within the conflict event. We may use face tactics to maneuver through the conflict episode.

Classifying and categorizing face tactics by conflict styles is an effective way to understand conflict and how people manage their conflict. For this reason, I divided the two face-tactic styles of defensive and restorative, as defined by various theorists (See Appendix O), into five categories, following the conflict styles of Blake & Mouton and Thomas & Killman. From this list, and from reading narrative interactions based upon the conflict themes that I identified, I concluded that face tactics and styles can be studied within themes, and when used within interactions, they are visible and can produce potential trends and patterns.

This research provided the means to identify conflict tactics used by nurses, specifically facework. And from their self-told stories of conflict, I was able to identify a large group of face tactics. Fourteen specific tactics occurred frequently in the interactions and were the most common used by the nurses. Of those fourteen (as

displayed in the previous chapter) five specific face-tactics were continually repeated through various elements of the conflict themes. The five most commonly used were:

1) Defensive – avoidance,

2) Defensive – competitiveness – responses – justification,

3) Defensive – competitiveness – competitive acts as presumptive remarks,

4) Restorative – accommodative – desire for harmony, and

5) Restorative – competitive – accounts – justification – appeal to value and logic.

The initial question in the interview was "what makes a good nurse and what makes a bad or problem nurse". This question was used to elicit a conflict event from the nurses; however, the same question developed a listing of face tactics (with these five being the most common). These five face tactics not only defined the nurses in the face tactics chosen in conflict situation, but in the nurses' own self-report of characteristics ('this is who I am'), these same styles emerged again, possibly supporting the idea that nurses portray certain conflict-tactics in face tactics.

From a macro view of the conflict themes and the face tactics that were used in the interactions, patterns of the defensive face were clearest. These defensive face-tactics place avoidance highest in their defensive style, followed by competitive-justification, and, finally, competitive-presumptive remarks. In effect, the nurses may first avoid the situation. But if it persists or involves an issue of best practice, safety or ethics, the nurses shift responses from avoidance to competitive with a justification of reason or confrontation, then uses presumptive or hostile remarks, questions or statements.

The second pattern of nursing face tactics was restorative. In the restorative mode the nurses represented two primary face tactics: 1) Competitive – Justification – Appeal for value and logic, and; 2) Accommodative – Desire for harmony. One interesting facet is that the nurses were competitive even in the restorative mode. They continued to try to make their point regarding practice, procedures or ethics by appealing to value and logic. Rarely, we also saw appeals to face or fairness. The only theme where this pattern was displayed more than once was in generational differences. The appeal to value and logic, as in "this is the right thing to do", surfaced again and again. The next restorative face tactic commonly seen is that of accommodative desire for harmony over competition about certain issues. At the same time, this tactic shows a level of commitment to teamwork among the nurses. The ability to keep a sense of civility, kindness and harmony appears to be important. Therefore, these explanations can answer research question #2, that there are certain face tactics that nurses use in defensive and restorative face work within a conflict interaction.

Other Outcomes and Implications

Patterns of nursing face tactics

From the visual listings and summaries, observable and recognizable patterns surfaced. These patterns identified specific face tactics as they related to other tactics, creating a linking process. While the conflict stories provided conflict themes for the profession, the face tactics provided an understanding of how the nurses worked through their conflicts. Examining the fourteen face-tactics most commonly used by the profession, I discovered the defensive posture outweighed the restorative, and the

competitive-style heavily outweighed all other conflict-management styles. This was repeated multiple times indicating that the nurses did not frequently confront situations unless it involved ethics or safety, a finding previously discussed. The face tactics support the view that this is a profession that approaches certain conflicts head-on and confrontationally – acting first and asking questions later.

Research has found that 30% of nurses are working outside the profession. Why? Some nurses cite compensation and/or undesirable working hours/shifts as a reason. It appears that this is only part of the story. This research indicates that, to survive and succeed in the profession, you must be able to "hold your own", "have a 'thick skin'", and be careful about "whom you cross." This was observed multiple times in the nurses' defensive stances using competitive statements and presumptive remarks when relating their interactions within a conflict. These stories do not portray nurses as a particularly forgiving group. I heard many stories of nurses blocking the goals of other nurses for reasons of practice, education, age and personal motivation (seen most often in the *slacker* narratives). While rigidity is undoubtedly an issue in the profession, such a narrow depiction judges nurses too harshly. Rather, nurses expect high levels of professionalism, performance, knowledge and responsible behavior. Not only do the conflict themes support this conclusion, the face tactics from the stories and the subsequent patterns give evidence to this assertive and competitive behavior-style. The 94 conflict stories revealed a characteristic style that was further supported by the nurses' self-descriptions.

Building one's cultural presence through face tactics.

From Goffman's theory of face and facework, a second outcome of the study surfaced. Goffman's (1955) theory explains face as the positive social value people claim for themselves in order to be seen in a positive light by others. Ting-Toomey and Kurogi (1998) further determined face to be a sense of social self-worth, one that individuals desire another to see. Relating face to culture, Ting-Toomey (1997; 2005) envisions face as a cultural-specific lens that can enhance and complement the social self or create conflict due to miscommunication over incompatible identity.

What is interesting in facework is the relationship that face tactics have to culture. Wilson (1992) says, "culture influences the role of face and facework in negotiation" (p. 200). But does face and facework influence culture? Can face actually shape or build a culture? Researchers such as Tylor (1924) and Scollon & Scollen (2001) have described culture as an ideology based upon history, beliefs, values and worldviews. An individual's ideology, which defines his or her culture, may also determine and reflect the face tactics chosen for an interaction. This was evident in the generational conflict theme, as well as the theme: "*this is who I am*." Various face tactics used within the generational theme openly identified the culture of the nurse. The "use of gloves" interaction told by Charlotte is a classic example of an older generation that is either not as concerned about the spread of blood-borne illnesses or is simply seeking to block the goal of the younger nurse by proving "the old ways work better." The older nurses know that the potential for illnesses exist; however, they assign it a lower priority. The younger nurse uses the interaction to demonstrate and build her generational age-culture, selecting

face tactics that may be more identified with her generation as opposed to the older generation: "I hope you're careful" (*Defensive – Accommodative – Enlisting politeness; FT-46/47*). In this interaction, the younger nurse appears to be more accommodative than confrontational or avoidant. This may be a characteristic of her culture and the culture's conflict management-style, contrasting to the older nurses' cultural style that utilizes an avoidant or confrontational tactic. Although the numbers are too small for an absolute conclusion, there is no doubt the nurses in the study demonstrate these differences.

Another excellent example of culture defining face tactics comes from a situation similar to Charlotte's but with a Nigerian nurse who does not wear gloves when working with a patient. Her response to the questioning nurse about 'gloving up' is, "I'll do it next time" (Defensive – *Competitive – Response – Excuses; FT-37*). The nurse's response can be defined culturally as a means of identification with her culture. Kathy, the nurse telling the story, sees this in cultural terms: "A lot of people will tell you that Nigerian nurses are a lot more standoffish, combative, less worried, but, I mean, that's been my experience." From Kathy's comment, we can surmise that culture can elicit certain face acts and certain face acts can also represent certain cultures. Kathy, in the Nigerian nurse story, states that she heard previous stories of Nigerian nurses and their culture, and the comment from the Nigerian nurse may solidify Kathy's perception of the culture. The Nigerian nurse's comment: "…next time" can be interpreted at least two ways. Is the use of gloves considered irrelevant to the Nigerian nurse and culturally unimportant? Or, due to lack of medical supplies in the region, are gloves a scarce luxury item in the healthcare system? Even if Kathy was acting on a stereotype, about Nigerian nurses, her tactics were influenced by her cultural views.

From the conflict themes and stories presented in this study, nursing culture appears to be influenced by generational, ethnical, and educational factors. Examples of face tactics reflecting culture and/or building culture are evident throughout the nurses' conflict stories. Some face tactics in the stories are not obvious culture-builders; however, in a review of the theme *"this is who I am,"* cultural face-tactics such as appeal to value, logic, reason and appeal to utilitarianism begin to surface and repeat throughout the interactions. Such tactics specifically reflect a culture influenced by age and educational/licensing credentialing. That is, tactics of confrontation related to put-downs for incompetence, challenges to ignorance, and assertions of credibility based on credentials serve to establish the importance of these elements in nursing culture. They do not just reflect the issues; they create the permeating basis of nursing professionalism. Through these face tactics, personality, statements of value and basic assumptions become visible. Therefore, it is suggestive that face tactics can both identify and build a culture just as a culture can prescribe the use of certain face tactics.

This understanding of identification and building of culture through face acts can be considered an extension of the theory of intercultural communication proposed by Scollen & Scollen. These scholars, building upon Longfellow model of generational culture, concluded that communication can define culture just as the culture can define or direct the communication. From the research, Scollen and Scollen (2001) concluded that cultural groups will communicate differently within as compared to between groups, and cultural groups find themselves trapped between ideologies and identities as they change communication style with other cultural groups. These findings help to support the findings of this study that face acts can be identified culturally as well as identifying a

culture by developing and impacting its communication. Subsequently, there is a relationship between this study and the theory of intercultural communication.

The face tactic listing.

The third outcome of the research was the identification of the ninety-six face tactics. What started as a simple undertaking developed into a massive search for every face-tactic ever identified by a scholar. While this was challenging and frustrating, it was extremely interesting to see face tactics surface in various disciplines. In the end, I realized that I had accomplished something that had been lacking —a complete, itemized and categorized list of face tactics that had been presented by noted theorists. Where before, we had only a random grouping of face tactics with no organization or pattern, I now had the tactics formatted in a manner which allowed for easy identification in text, quotations and interactional dialogue.

Newly identified face tactics.

Related to the third outcome is the identification of new face-tactics. Eleven new face-tactics were discovered, as discussed in the previous chapter. These eleven face tactics, not seen before in the literature, were identified as I analyzed the transcripts for known face-tactics. When known face-tactics could not be matched to these face-act responses, then a new face-tactic was constructed and categorized by conflict style using the specific quotation from the nursing interactions (see Appendix L).

Summary

This chapter was used to address issues about face and face tactics within conflict interactions. First, RQ2, the second research-question exploring face tactics in nursing conflict themes and interactions, was demonstrated through the nurses' use of fourteen repeating, specific face-tactics. Five of these tactics repeated multiple times throughout the nursing-conflict stories. Next, various outcomes from the face results were discussed. In this discussion was an extension of current face-theory by addressing that face tactics, along with being cultural specific, also may be industry or profession specific. This could extend the intercultural face-research of Scollen and Scollen, and Ting-Toomey in facework as it relates to intercultural communication. The identification of 96 face tactics as categorized by conflict management style provides an up to date list of theorists' identified face-tactics, and supports and expands Ting-Toomey (2005), which states: "facework is not equivalent to conflict styles…that conflict styles can include specific facework tactics" (p. 78). And lastly, with the discovery of eleven new face-tactics and insights into face as a change agent in conflict and negotiation, I surmise that the concept is ripe for continued investigation and inquiry.

Chapter Eight: Limitations, Future Directions and Conclusion

Limitations

The research study was an overall success as it addressed and answered research questions regarding communication conflict themes and face tactics used by nurses in conflict interactions. However, there are limitations to the study that should be noted.

The first and second limitation was the sample set as limited by both ethnicity and gender. Regarding gender, the Texas Department of State Health Services Center for Health Statistics (2010) states that in 2009, 89.3% of the nurses in Texas were female and 10.7% were male. My dataset did not reflect these numbers as I had only one male. I received less than a 5% response from males in my invitation to participate in the research. This could be due to the characteristics of the male nurse. Most are ex-military and have families. They work traditional shifts and may not be as enticed by money as their female counterparts, who are more often single with children, divorced and/or working weekend shifts to attain additional funds. Future research should seek to analyze more male nurses in face and conflict.

Another avenue for future research regarding male nurses would be examining if they follow current trends in how genders communicate at work. To my knowledge, there has been no research in male-to-male or male-to-female conflict face-tactics interaction within nursing. Additionally, does a male nurse experience the same communication conflict themes as the female? Is age, ethics and best practice an issue to them as the research showed it is to the female nurses in the study? Female nurses did not report any conflict with their male counterparts as colleagues or supervisors; however, the male nurse, Jacob, did report issues of conflict with his female supervisor.

In addition, he described as "non-important" issues that the female staff identified as areas of concern. Future research could easily investigate multiple gender issues that may exist in nursing.

Ethnicity became the second and more concerning limitation to the study. Where I had originally been concerned about interviewing too many staff members from the same healthcare facility (hospital), I soon realized that this was not an issue. I received a broad representation from every hospital in the south Central Texas area including facilities as far as 50 miles away (with the exception of a heart specialty hospital in Central Texas). The concern I did encounter was a lack of ethic representation in the study. According to the Texas Department of State Health Services Center for Health Statistics (2010), the ethnic breakdown of the Texas population and nurses as compared to this study's demographics are:

Ethnic Group	Texas Population	Texas Nurses	Study Nurses
White	45.9	68.0	75.0
Black	11.6	9.7	0.0
Hispanic	38.1	11.3	12.5
Other (Including Asians)	4.4	11.0	12.5

From these numbers, two things are apparent. First, Central Texas (specifically Austin) nurses are not representative of the state's population as the Hispanic population is under-represented in the profession. However, the greater importance is the lack of black nurses in the research study. The other three categories of White, Hispanic and Other were fairly similar to the state's nurse-demographics. However, in reviewing all applicants who responded to the research study inquiry, I found that only one black nurse

expressed an interest. She then failed to respond to a request to schedule an appointment. The same reporting service providing state demographics also provides a trend in nursing from 2006. From 2006 to 2011, black nurses decreased from 11.3% to 9.7%, with white nurse numbers increasing in Texas from 56.9% to 68%. This decrease could provide an answer as to why fewer black nurses responded; however, demographics show a greater black population within the eastern regions of the state. This likely affects the number of black nurses that reside and practice in the Central Texas area. Therefore, I became aware that this research study is very geographically defined. A study of the Texas Valley nurses would weigh heavily toward a Hispanic representation, whereas a study that was accomplished in the Texas Panhandle would look different ethnically, perhaps mirroring the Midwest United States.

Contrary to the conclusion of Barbee (1993) that racism is a current issue in nursing, preventing the growth of black nurses within the profession, I discovered no systematic or widespread racism. This limitation does open the door for future research that includes black nurses in the data set. There may be interesting findings in generational face tactics. Barbee (1993), in her research, alludes to issues of racism in the nursing profession between Euro-American nurses and African-American nurses. In her report, she does mention generational diversity as a contributing factor, but only in a minor sense.

The third limitation of the study is that of geography. As stated earlier, the participants came from a broad mix of hospitals within the local area. These hospitals ranged from medium (150+ beds) to large (500+ beds). The facilities represented both non-profit and profit, adult and pediatric care, acute and emergency care, rehabilitation

and skilled nursing care (non-rehabilitative). This was a surprisingly good mix; however, the conflict themes and face tactics represent only the characteristics of residents of Central Texas, known as an area of:

- middle to upper class residents;
- decreasing families-with-children,
- an urban core,
- a slide in the black population,
- a strong growth in Hispanics,
- a skyrocketing Asian presence,
- a sharp increase in affluence,
- an intensity toward urban growth and living instead of rural or suburban (Robinson, 2010).

This is not an example of most American cities. Therefore, attempting to compare the results of this study to a study in a different geographic location may be difficult due to the demographic trends of the area. Still, any future research in nursing conflict and face tactics may yield similar findings as nurses are not typically native to their worksite. Many of the interview participants, especially the older nurses, reported their current residence was the result of following their husband's job, or pursuing an economic or career surge in the area. Therefore, this limitation may open doors for future findings in regional facework and tactics.

Future Directions and Discussion

Future research opportunities suggested by the limitations of this study's demographics/representativeness include gender, ethnicity and geography. However,

more exciting is the new and enticing research that the current study can unlock. In this section, I will discuss future-research opportunities that surfaced as the result of this study. As researchers, we endeavor to produce meaningful findings. For that reason, I have listed below research possibilities that I see as beneficial to the betterment of not only the nursing profession, but also the growing discipline of communication studies.

Understanding face and the taken-for-granted assumptions of employees.

Edgar Schein's (1990) writings on organizational culture pose two ideas that are important to a broad view of face at work.

1. Employees choose to act in certain ways not because of threats or promises, but because, in doing so, they are consistent with their taken-for-granted assumptions about their own identity and their roles within the organization regarding how to act and respond appropriately to the actions of their fellow employees (Clegg, 1979).
2. An organizational employee's power is exercised through four symbolic forms: promising, rationalizing, threatening and justifying (Conrad & Ryan, 1985).

The second statement directly relates to how individuals use facework and face tactics as a means of control and power. Excerpts from the earlier conflict-interactions show individuals switching back and forth between various face tactics in an effort to maneuver the opposing party closer to their way of thinking. Rationalizing, justifying and threatening are viewed in both the defensive and the restorative face-saving modes. Promising, however, is a face tactic that did not surface, at least not in the traditional sense. Instead, I viewed the concept of promising in facework as a means to elevate or build the person's presence in the eyes of the other party. This building through facework will be discussed in greater detail later in the chapter.

However, the first statement relates to how individuals can employ different face tactics to break the 'taken-for-granted' assumptions of their fellow employees' and managers' conflict styles. This is an area for a future research project, one that I sense could create an extension to the current research in facework and face acts.

The interviews in this study showed evidence of how individuals change, alter and move within various face-acts depending upon their desired outcome. Certain conflict themes directly relate to the taken-for-granted assumption. For example, in the conflict theme: "*You really don't know what you are doing",* the approaching nurse has already assumed that the offending nurse is ignorant to an event or knowledge. The offending nurse would show the taken-for-granted stance in her use of defensive avoiding tactics, such as evasive remarks, fleeing, pretending not to notice, and changing topics. These face tactics would move the approaching nurse to either a defensive-competitive mode or restorative-competitive mode (extreme comments or appeal to value/fairness, respectively). It was noted that the defensive face-mode did not always result in a failed interaction and, correspondingly, the restorative face-mode did not always create a resolved conflict. What was apparent, however, is that the use of the face tactic of Appeal to Fairness or Value was more successful by the offending nurse in explaining his/her position than it was for the approaching nurse, who used it as an initiating statement or rebuttal of irritation. However, in stories of taken-for-granted nurses, these face tactics of "appeal" are not evident. Instead, the avoidance/evasive face-tactics appear to be the tactic of choice for the nurse and, subsequently, the conflict interaction may only be postponed until a later date.

Also shown within the research was evidence that, when a person does not recognize the face tactics of another, and does not alter his or her own conflict stance and/or facework, the conflict often continues with a lack of conflict management and/or resolution. This was apparent in interactions where both parties remain defensive and competitive. The conflict stories of *Don't make me come after you* (another taken-for-granted assumption) provide the best examples of competitive responses, showing questions and statements resulting in returned competitive comments, blocking, refusal and put-downs. While this may seem obvious, the research showed that the interaction in these situations stopped quickly and abruptly after one or two rebuttals. Contrastingly, when one party shifts to a restorative stance (acceptance, appeal to value, or even humor as an avoidance technique), the interaction continues with multiple rebuttals and occasional resolution of the conflict (e.g., Kelli and the story of the CNA who forgets to report the abnormal vital signs before leaving her shift). Regarding the taken-for-granted assumption in organizations, it appears that the recognition or use of certain face-tactics, and the pattern of their use, can adversely affect the outcome of the situation by means of the responding face-tactics.

Continuing on the issue of how certain face tactics relate directly to other face tactics, further research could explain how they are associated and create certain responses within certain conflict-style categories. This was one of the reasons why I chose to categorize face tactics within conflict styles—to allow for identification with a style and to look for patterns of responses regarding how certain face-tactics affect other face-tactics. To extend this concept and to accomplish this type of future research, I would enlist participants with stories that use a defined conflict-style face tactic. For

example, how does the use of restorative competitive personal-idioms enlist certain face tactic responses? Do they cut or cease the communication process? By using labels, nicknames, teasing insults and confrontation, does the responder remain confrontational? Or do they move toward avoidance (defensively or restoratively)? The same question could be applied to the restorative use of accounts justification.

In the research data, the appeal to value and logic was repeatedly used (as quoted in the preceding paragraph); however, it did not have a set response by way of any certain face-tactic. Perhaps situational factors outweighed personality factors. A situational factor would be an event, such as a patient in cardiac arrest, rather than a personality factor like an individual attitude, characteristic or basic assumption (e.g., the taken-for-granted assumption of a staff member). But, if we were to analyze the responder's personality factors in terms of the conflict management style and de-emphasize the situation, would the responding face-tactic of justification in terms of appeal to value and logic succeed or fail? Again, the way to approach this is through finding participants that are in similar situations but who practice different conflict management styles.

Identifying and matching conflict styles and the style's face tactics to other face tactics and styles can play an interesting role in developing new conflict training benefiting practitioners, educators and consultants. As for nurses, incorporating facework and conflict training into nursing curriculum can further help to demonstrate how face tactics in the profession can ignite or defuse conflict during certain interactions.

Building face as a means of facework.

The second proposed future research is not of defending or restoring face, but of building face, specifically building value to one's face. We understand from Goffman

(1955) that face is "an image of self-delineation in terms of approved social attributes" (p, 213). Specifically, it is an image seen by others that is usually assigned to a specific situation. This makes complete sense as we evaluate the importance of restoration of face or the defense of face. But does the management of face stop there?

Face, for many, is considered a component of conflict management; however, it would be a major misunderstanding to assume that all facework is only thought of as conflict-based. Face can also be used positively both inside and outside of conflict to create a better image for the individual. Ting-Toomey and Kurogi (1998) determined face to be a sense of social self-worth that one desires others to see. The various face tactics listed in Appendix O are divided into different conflict-styles that allow for the assignment of the face tactics used in the study. However, several times the face acts of the participants were not a clear means to managing a conflict. Occasionally, they were being used to build credibility and value in the eyes of the other person. How is this different from defending and restoring face? In both defense and restoration, the individual is attempting to maintain a positive face. They are acting upon the premise that the face is in jeopardy or danger. Contrarily, if you do not sense face danger, would you strive to use face tactics? It is suggested that the use of face tactics when there is no face danger is to build the value of the individual by selecting certain face-tactics that encourage a positive view of the individual's face in the eyes of the opposing party.

It would be incorrect to say the concept of 'building face' is new. Penman (1990) addressed this same issue over thirty years ago, envisioning face in two categories: self-directed; and other-directed. Penman states that both "self" and "other" reside in and out of conflict by means of four methods: mitigation/enhancement; protection; threatening;

and aggravation/depreciation. It is the self-directed that Penman describes as a means to 'build' face for the individual. According to Penman, this micro-strategy of facework extends the Politeness theory of Brown and Levinson by asserting that face has multiple strategies and goals. Among them is the goal of being able to enhance self by removing the focus from the other to self (Penman, 1990). This concept of expanding face goal through enhancement has not been widely studied, though the reason is not clear. Ting-Toomey & Kurogi (1998) compared self-directed facework to the concept of individualism in their explanation of individualism vs. collectivism in cultural communication. However, again, since the 1990s, scholarly research in this concept of using face inside and outside of conflict to build self is all but absent.

Similar to Penman, I believe that building face can become a common and popular event for individuals who see an opportunity to use face tactics in a strategic role to improve their image in the eyes of the other party. From the study's interviews, I recognized certain cases where the individual, not seeing a need for defense or restoration, uses the opportunity of the interaction to increase, strengthen or further the image in the eyes of the other party by employing face tactics. Because the interviews of my study concentrated on conflict interactions, the only examples I can provide of face building would come from a conflict where both parties are opposing each other. In the examples below, you will notice that, in the midst of the conflict interaction, there are times when one party is neither defending nor restoring face. Rather, the individual is feeling secure in the position and subsequently using face tactics to build the image in the sight of the other. The following examples are pulled directly from the study's interview transcripts and all comments and statements are rebuttals, not originating remarks. I

believe that usual face-building tactics are easily seen as just stand-alone statements. What I found was that, in the middle of an interaction, one party would make a statement that may or may not have a restorative or defensive face stance but, instead, it contains a value drive toward building face.

1. Kelli as she apologizes but also explains why.

Kelli: "And I was like, 'okay, so, now you know that these are the perimeters and you need to let me know as soon as possible if there is something wrong.' I wanted to make sure that she understood and that, you know, we were okay, and I said, 'I'm sorry, you know, I talked quickly or short to you, but it was very important.'"

During the conflict interaction, Kelli leaves the typical stance of defending her actions and moves toward the explanation of her superior knowledge to the nurse assistant. Kelli does apologize for her way of communicating; however, she shows in her apology that she never felt threatened in the altercation requiring her to defend her face. Kelli does show face restoration because she is concerned about her abrupt communicative style to the assistant and the possible future implications it could have on their working relationship.

2. Regarding Kathy as she explains her position to the Lab.

Kathy: "The lab, they're condescending, and they said like, 'you're not understanding what I'm saying. You're being stupid.' And I was like, 'what? No. Whatever. Okay.' And like, 'thank you, but, you're in the Lab, I'm up here. I know what's going on.'"

This interaction between Kathy and the lab provides an example of credentialing; however, it is not well-defined if Kathy was defending face. Kathy's statement of "Whatever, Okay" would imply that she did not feel threatened by the lab's comment. As I consider the 'lack of feeling threatened' as a basis for building value by facework, I judge Kathy's response of "I'm up here. I know what's going on," to be an explanation of knowledge and a 'don't mess with me' stance of defiance. Therefore, this position of defiance makes me consider value building not as a defense mechanism to block an attack, but rather as a means to strengthen your character to deter and discourage future attacks.

The examples presented above from the interview transcripts suggest that there may be 'building face' in the use of face tactics. I believe there is more to be learned. Just as certain face tactics can be identified with defensive and restorative facework, I believe selected face tactics can be identified with face building, a topic theorized by Penman, as a means to enhance self to others. Penman touched on micro-strategies in facework with limited examples; however, where else can this research go? And what other face tactics can be observed in self-directed enhancing facework beyond Penman's research? It may be a turn to politeness theory (Brown & Levinson) to study positive and negative face presentation or to Goffman's broader notions of self-presentation to further pursue face-building.

Linking conflict styles to face tactics.

The third proposed future research comes in the form of conflict management and negotiation. The data showed that face tactics play a pivotal role in conflict interactions.

They help to maintain a person's ability to engage or disengage from different conflict-styles, such as avoidance, competitiveness, accommodative, compromise and collaborative. Simultaneously, they provide the avenue for the individual to determine what manner of face tactics the person desires to portray: maintaining the current face; creating a new face; or defending or restoring (saving) the existing face. I approached this research knowing that some scholars view the Blake & Mouton conflict grid/management style and the Thomas-Killman conflict mode instrument as less than scholarly. I view the Blake & Mouton grid and the TKI assessment—as supported by the Wharton-TKI Bargaining styles grid—as an effective and valid system for classifying (Shell, 2001). I credit these instruments for providing an effective categorical system for analyzing face by creating a link of face tactics to a conflict style that can be explained and managed by understanding the characteristic of other conflict styles (Witheres & Wisinkski, 2007).

Supporters of the conflict-management styles of Blake & Mouton and Thomas-Killman have asserted that better negotiation skills come from an understanding of one's own conflict-management style, as well as that of one's opponent. My research in face tactics may suggest a further conclusion. Having identified face tactics by conflict-management styles, would choosing face tactics by means of the conflict style assist in conflict management and resolution? Would recognizing a conflict-management style by face tactic help to identify a complementary conflict-style, providing the face tactics that best addresses and manages both the other's conflict style and the general conflict situation? While this process sounds novice and elementary, it was clear from the participant interviews that this method was being used by some, but not by others.

Study Conclusion

This study began with a statement that subtle use of conflict tactics provides for different levels of engagement or avoidance of a conflict. The party can defend and/or restore a positive face through engagement or avoid the situation in an attempt to either allow the conflict to disappear with time or to create a negative face to establish total autonomy. Face then plays a pivotal role in a person's choice to move between different conflict styles such as avoidance, competitiveness, accommodativeness, collaborating, and compromising. Simultaneously, these different conflict-styles provide the avenue for determining what manner of face tactics the person chooses to portray—the current face, to create a new face, or simply to defend or restore the existing face.

The analysis of the data answers both of the stated research questions and gives light to these concepts:

1. Conflict themes in nursing can be recognized and categorized through the analysis of narrative stories of conflict interactions.

2. Face-saving tactics within conflict interaction in nursing can be identified and categorized within context of their ability to defend, as in defensive, or to restore, as in restorative, the face of the individual.

3. Patterns can be identified within face tactics and conflict themes that can address how nurses select face tactics and approach professional conflict-interactions.

4. A composite and categorized listing of theorists defined face-tactics has been developed to better assist in the understanding and identification of face acts. This

listing (displayed in Appendix O) pulls together all the identifiable face-tactics of numerous theorists and compiles them into a single table.

5. Eleven new face-saving tactics were identified through the conflict interactions of staff nurses to defend and restore current face.

We know that conflict is inevitable and will occur any time two people with different views are interdependent. Although their goals may often be similar, as in the case of most nurses, they will encounter conflict as they enact their learned body of knowledge and practice, their experience and their understanding of what makes a "good nurse." This study provided a personal and contextual view of what nurses encounter on a daily basis and how, in some cases, it affects the performance of their practice and the care of their patients. These same nurses are faced with many challenges, from patient abuse, to doctor and administration abuse. Their job is not easy. They learn early in their careers to take care of themselves and to protect their most important attribute, their license. Sometimes this protection stance creates conflict between nurses. By studying conflicts that they encounter while defending their actions, stance and attributes, we can recognize corresponding face-tactics that are used to defend or restore the face of the nurse in a conflict interaction. With this information, there is the possibility for immense benefit for the profession in dispute identification, management and resolution. This is particularly relevant as our healthcare environment continually changes with nurses taking on greater and more demanding roles in patient care and administration.

Our understanding of the traditional nurse is changing. The new nurse will become the general-medicine practitioner of the future. They will have a greater number

of titles and educational avenues, some more advanced and some less than today's lowest nursing level. Conflict in the profession is likely to escalate. As society moves toward this uncharted healthcare-territory, understanding conflict and face may become paramount to the success of the profession. It is my hope that my research in this missing piece of nursing conflict and face leads to a betterment of the profession and its transition to an uncertain future. In addition, I hope to broaden our understanding of the current research of face. My intent was twofold. First, I wanted to extend the current research in facework by identifying new face-tactics and new means to save face. Secondly, I wanted to create a tool that assists in the observation of face tactics by compiling a table of the numerous face tactics identified over the years by communication theorists. In undertaking these two tasks, I was striving to advance the current understanding of face and face tactics by inciting new insights and attempting to instigate an extension of past communication theories of face and conflict.

Appendix A

Means Importance Ratings of Nine Communication Skills between Nurse to Nurse

Type of Communication	**Mean**	***N***
Listening	4.87	253
Routine information exchange	4.69	254
Management of conflict	4.57	242
Small group/conference	4.48	252
Instructing	3.85	246
Advising	3.65	253
Giving orders	3.55	231
Public speaking	3.54	217
Persuading	3.16	224

(From: Morse & Piland, 1981)

Appendix B

Types of generations by cited authors

Ages	Zemke et al.	Gravett & Throckmorton	Strauss & Howe	Conger	Harwood et al	Longfellow/Scollon	Seccombe & Kuntz	Zepelin et al. Kite & Wagner
90s			G.I. (civic) 1901-1924		Elderly	Authoritarian 1914-1928	Oldest Old 85+	
80s	Traditionalist, Veterans 1922-1943	Radio Babies, G.I. 1930-1945	Silent (adaptive) 1925-1942	Silent 1925-1942	Elderly	Depression 1929-1945	Old 75-84	
70s					Elderly		Young Old/Old	
60s	Boomers 1943-1960	Baby Boomers 1946-1964	Boom (idealist) 1943-1960	Boomers 1943-1960	Elderly	Baby Boomers 1946-1964	Young Old 65-74	Old 65+
50s					Elderly Middle-age			
40s	Post Boomer Generation X 1960-1980	Generation X, Gen Xer 1965-1976	Thirteenth (reactive) 1961-1981	Busters 1961-1981	Middle-age	InfoChild 1965-1980		
30s					Young			Middle age 35-60
20s	Nexters, Gen Y 1980-2000	Generation Y 1977-1990	Millenials (civic) 1982-2003	Millennials 1982-2003	Young			Young 18-35
10s		Generation Z 1991 and later			Young			

(As derived from: Gravett & Throckmorton, 2007; Zemke et al., 2000; Strauss & Howe, 1991; Conger, 1997; Harwood et al., 1994; Longfellow, 1978 and Scollon & Scollon, 2001; Seccombe & Kuntz, 1991; Zepelin et al., 1987 and Kite & Wagner, 2004)

Appendix C

Participant's demographics

Name	Age-Gen	Status	Race	Lic.	Degree	Salary	TKI report				
							AVOID	ACC	COLL	COMPT	COMPR
Sarah	29-F	Married	Asian	RN	BSN	$45-59K	49	87	41	10	75
Patti	30-F	Married	Asian-Caucasian	RN	BSN + Grad wk	$24K	95	87	74	10	3
Jane	32-F	Single	Caucasian	RN	ADN	$25-34K	88	98	3	31	27
Kathy	33-F	Married	Hispanic	RN	BSN + Grad wk	$25-34K	49	2	58	57	95
Jackie	34-F	Single	Caucasian	RN	ADN	$60-74K	22	30	15	79	95
Janet	51-F	Divorced	Caucasian	RN	ADN	$75+	65	100	15	20	27
Karla J.	31-F	Single	Caucasian	RN	BSN + BS	$35-44	49	46	41	57	58
Janice	35-F	Single	Hispanic	RN	BSN + MSN	$45-59K	49	98	7	10	87
Charlotte	42-F	Married	Caucasian	RN	BSN	$45-59K	88	62	26	10	75
Jasmine	39-F	Married	Caucasian	LVN + RN	ADN + BS	$60-74K	78	76	1	79	41
Abigail	44-F	Married	Caucasian	RN	BSN	$15K	65	30	7	87	58
Chelsea	23-F	Single	Caucasian	RN	BSN	$35-44K	49	62	41	20	87
Jeri	29-F	Single	Asian	RN + NP	BSN + MSN	$35-44K	98	76	26	3	41
Kelli	30-F	Single	Caucasian	RN	BSN + Grad wk	$25-34K	95	62	3	31	75
Ashley	50-F	Married	Caucasian	RN	BSN + MSN	$45-59K	22	62	41	20	99
Brooke	28-F	Married	Caucasian	RN	BSN + BS	$35-44K	49	94	26	31	41
Helen	35-F	Single	Caucasian	RN	BSN	$60-74K	88	7	26	69	58
Juliet	53-F	Married	Caucasian	RN	BSN	$25-34K	95	87	41	20	7
Mary	53-F	Divorced	Caucasian	LVN	BA + Grad wk	NR	49	94	3	79	27
Jacob	29-M	Married	Hispanic	LVN	Some College	$45-59K	34	98	26	20	58
Donna	59-F	Divorced	Caucasian	RN	BSN	$60-74K	78	62	26	3	95
Rose (Pilot Study)	58-F	Married	Caucasian	RN	BSN + MSN	NR	NR	NR	NR	NR	NR
Julie St. (Pilot Study)	43-F	Married	Caucasian	RN	BSN	NR	NR	NR	NR	NR	NR
Rachel (Pilot Study)	25-F	NR	Caucasian	RN	BSN	NR	NR	NR	NR	NR	NR
						SUM	**1354**	**1420**	**547**	**746**	**1229**
						AVERAGES	**65**	**68**	**26**	**36**	**59**

TKI	1st Profile	7	8		2	6
TKI	2nd Profile	6	5	1	4	5
TKI	3rd Profile	6	5	3	2	5

AVOID = Avoid
ACCOM = Accommodate
COLL = Collaborate
COMPETE = Compete
COMPRM = Compromise

This chart provides the demographic information and the TKI scoring for each participant from this conflict study. This data is subsequently used to create other charts and tables. Key factors in these demographics are the age, the education and the TKI interpretive report's numeric total that provides the participant's primary, secondary and third conflict management style.

Appendix D

Confession of the Researcher

"In some instances, the confessional tale stems from the notorious sensitivity of a fieldworker to aspersions cast on the scientific status of their undertaking. [They] do not replace realist accounts. They stand beside them, elaborating extensively on the formal snippets of method description that decorate realist tales." (Van Maneen, 1988, p. 73, 75).

A researcher is not just an individual reading data and observing conflict in the workplace. I see myself as an interpreter of acts and interactions, in this case, related to facework stories (Van Maneen, 1988). Anyone can sit in the field and listen to stories but it takes a translator, a person with knowledge and history in the profession or industry, to understand and communicate those interactions in a way that is meaningful and insightful. I believe that insight incites understanding. Regarding face and facework, my knowledge is purely academic. I maintain the same knowledge that most graduate students possess from watching, questioning and inquiring. It is my knowledge of the nursing profession that lends a practical insight to my method of study.

I have been involved with the nursing profession, personally and professionally, for over 30 years. Professionally, I have worked with and interviewed nurses to develop financial products for the banking industry. I have worked extensively in the development of nurse recruitment and retention programs administered by individual healthcare organizations and professional associations. Personally, I married a RN. For the first two years of our marriage, I sat for hours in the UT-Austin nursing school, overhearing lectures in nursing practice. Our friends, for the most part, were nurses. For the first ten years of our marriage, our world revolved around hospital shift-work at an

inner-city hospital staffed by people from various generations and ethnic backgrounds. For three decades, I have lived, lingered and lunched with nurses in professional and personal environments. I recognize and appreciate their attributes and their devotion.

The nurse of the 1960s and 1970s is much different from the nurse of today. The days of white dress uniforms and starched nurses' caps are gone. Gone are the concepts of 'the patient is always first', 'never diagnose without the doctor', and 'you stay until the charting is done'. Nurses of that earlier era proudly wore their nametags with the appropriate RN, or LVN license advertised. On their lapel rested their college pin awarded to them upon receipt of their diploma. As the decades progressed, the nursing world changed. The uniform has slipped into scrubs with many facilities allowing for 'casual Fridays' complete with jeans and t-shirts. The once visible RNs and LVNs have been replaced with medical assistants and technicians who occasionally conceal or remove their nametags while maintaining their position as 'nurse'. Some facilities have resorted to initials to present the individual's position in the organizations—BA and MA—designations that refer not to Bachelor or Master of Arts, but rather business associate or medical assistant. The RNs and LVNs are still present, but in fewer numbers, many of them having left the healthcare arena for more profitable ventures in insurance, organizational and clinical research.

Based on my long experience with the industry, I admit to my biases. I am biased about a profession that has been dumbed down in many ways by a culture driven by corporate profits and the desire for institutionalized medicine. Still, this is a profession that is proud of its achievements and accomplishments. Nurses enter the industry to follow a passion for caring for the needy and for helping those who cannot help themselves. Each year, during National Nurses Week, thousands of nurses are reminded

that they reside in a profession that is based upon 'Excellence, Knowledge, and Compassion'. This call reminds nurses of their history and drives them to continually reinvent their profession. Johnson and Johnson developed advertisements that speak to the challenges of the changing nurse. The website www.discovernursing.com is a testament to our society's intent to restore the image of the professional nurse. So my confession—I regret the loss of the professional nurse. I cringe when a newly 'board certified', non-degreed 'nurse' or technician gives me an injection alarmingly close to the sciatic nerve. I sigh with concern when the young nurse does not ask the doctor but diagnoses the condition herself. Then I worry about the older nurse that sees no problem with mixing certain medications without consulting the PDR (Physician Desk Reference) for drug interactions. I am partial to the old ways but appreciative of the new ones.

So where does this leave me as a researcher? I am left with an abundance of history, thoughts, knowledge and insights into a striving profession. I bring to the research table the desire to look, listen and question something that has been personally meaningful to me for years. I bring the big question—how do nurses clash yet continue to successfully practice together? My findings show this is nothing unusual but confirm the nursing profession is ripe for study. In few other professions (e.g., school teachers) is there a group of members without seniority due to age, experience, technological savvy or, in some cases, education. As a researcher, I have to confront my biases. It is part of the difficult task of taking on any arena where you have a personal background. I do not, however, see my insider's view as a means to understanding the issue or establishing authority for new research in nursing communication. It does, I hope, make me a good—and interested—listener. What better place to start qualitative research than with the stories of nurses?

These stories portray an industry that has changed through the years. That evolution continues today, a realization that drove my research. Research based on a personal history allows for the interchange between my knowledge, values and beliefs and new, empirical data that can lead to altered perceptions. My goal was to join those elements in a realm of understanding, more fully exploring the subject and articulating that elusive connection between practice and theory (Cutcliffe, 2000).

Appendix E

Alphabetical Listing of Nursing Related Credentials

A

- AAS - Associate of Applied Science
- AAN - Associate of Arts in Nursing
- ACLS - Advanced Cardiac Life Support (not intended for postnominal use)
- ACNP - Acute Care Nurse Practitioner
- ACRN - AIDS Certified Registered Nurse
- ADN - Associate Degree in Nursing
- ALNC - Advanced Legal Nurse Consultant
- ANP - Adult Nurse Practitioner
- AOCN - Advanced Oncology Certified Nurse
- AOCNP - Advanced Oncology Certified Nurse Practitioner
- AOCNS - Advanced Oncology Certified Clinical Nurse Specialist
- APN - Advanced Practice Nurse
- APRN - Advanced Practice Registered Nurse
- ARNP - Advanced Registered Nurse Practitioner
- ASN - Associate of Science in Nursing

B

- BCLS - Basic Cardiac Life Support (not intended for postnominal use)
- BM - Bachelor of Midwifery
- BN - Bachelor of Nursing
- BSN - Bachelor of Science in Nursing

C

- CANP - Certified Adult Nurse Practitioner
- CAPA - Certified Ambulatory Perianesthesia nurse
- CARN - Certified Addictions Registered Nurse
- CCCN - Certified Continence Care Nurse
- CCM - Certified Case Manager
- CCNS - Certified Clinical Nurse Specialist
- CCRN - certified in critical care nursing
- CCTC - Certified Clinical Transplant Coordinator
- CCTN - Certified Clinical Transplant Nurse
- CCTRN - Certified Critical Care Transportation Nurse
- CDDN - Certified Developmental Disabilities Nurse
- CDE - Certified Diabetes Educator
- CDMS - Certified Disability Management Specialist
- CDN - Certified Dialysis Nurse
- CDONA/LTC - Certified Director of Nursing Administration/Long Term Care
- CEN - Certified Emergency Nurse
- CETN - Certified Enterostomal Therapy Nurse
- CFCN - Certified Foot Care Nurse
- CFN - Certified Forensic Nurse
- CFNP - Certified Family Nurse Practitioner

- CFRN - Certified Flight Registered Nurse
- CGN - Certified Gastroenterology Nurse
- CGRN - Certified Gastroenterology Registered Nurse
- CHN - Certified Hemodialysis Nurse
- CHPN - Certified Hospice and Palliative Nurse
- CHRN - Certified Hyperbaric Registered Nurse
- CIC - Certified in Infection Control
- CLNC - Certified Legal Nurse Consultant
- CMA- Certified Medical Assistant
- CM - Certified Midwife
- CMCN - Certified Managed Care Nurse
- CMDSC - Certified MDS Coordinator
- CMSRN - Certified Medical—Surgical Registered Nurse
- CNA - Certified in Nursing Administration
- CNA - Certified Nursing Assistant
- CNAA - Certified in Nursing Administration, Advanced
- CNA-A - Certified Nursing Assistant, Advanced
- CNE - Certified Nurse Educator
- CNI - Clinical Nursing Intern
- CNLCP - Certified Nurse Life Care Planner
- CNM - Certified Nurse Midwife
- CNN - Certified in Nephrology Nursing
- CNNP - Certified Neonatal Nurse Practitioner
- CNOR - Certified Nurse, Operating Room
- CNO - Chief Nursing Officer
- CNP - Certified Nurse Practitioner
- CNRN - Certified Neuroscience Registered Nurse
- CNS - Clinical Nurse Specialist
- CNSN - Certified Nutrition Support Nurse
- COCN - Certified Ostomy Care Nurse
- COHN - Certified Occupational Health Nurse
- COHN/CM - Certified Occupational Health Nurse/Case Manager
- COHN-S - Certified Occupational Health Nurse—Specialist
- COHN-S/CM - Certified Occupational Health Nurse—Specialist/Case Manager
- CORLN - Certified Otorhinolaryngology Nurse
- CPAN - Certified Post Anesthesia Nurse
- CPDN - Certified Peritoneal Dialysis Nurse
- CPHQ - Certified Professional in Healthcare Quality
- CPN - Certified Pediatric Nurse
- CPNA - Certified Pediatric Nurse Associate
- CPNL - Certified Practical Nurse, Long-term care
- CPNP - Certified Pediatric Nurse Practitioner
- CPON - Certified Pediatric Oncology Nurse
- CPSN - Certified Plastic Surgical Nurse
- CRN - Certified Radiologic Nurse
- CRNA - Certified Registered Nurse Anesthetist
- CRNFA - Certified Registered Nurse First Assistant
- CRNI - Certified Registered Nurse Intravenous
- CRNL - Certified Registered Nurse, Long-term care
- CRNO - Certified Registered Nurse in Ophthalmology
- CRNP - Certified Registered Nurse Practitioner
- CRRN - Certified Rehabilitation Registered Nurse
- CRRN-A - Certified Rehabilitation Registered Nurse—Advanced

- CS - Clinical Specialist
- C-SPI - Certified Specialist in Poison Information
- CTN - Certified Transcultural Nurse
- CTRN - Certified Transport Registered Nurse
- CUA - Certified Urologic Associate
- CUCNS - Certified Urologic Clinical Nurse Specialist
- CUNP - Certified Urologic Nurse Practitioner
- CURN - Certified Urologic Registered Nurse
- CVN - Certified Vascular Nurse
- CWCN - Certified Wound Care Nurse
- CWOCN - Certified Wound, Ostomy, Continence Nurse

D

- DN - Doctor of Nursing
- DNP - Doctor of Nursing Practice
- DrNP - Doctor of Nursing Practice
- DNS - Doctor of Nursing Science

E

- EdD - Doctor of Education
- EN - Enrolled Nurse
- ENPC - Emergency Nursing Pediatric Course (not intended for postnominal use)
- ET - Enterostomal Therapist

F

- FAAN - Fellow, American Academy of Nursing
- FAAPM - Fellow, American Academy of Pain Management
- FAEN - Fellow, Academy of Emergency Nursing
- FNC - Family Nurse Clinician
- FNP - Family Nurse Practitioner
- FPNP - Family Planning Nurse Practitioner
- FRCN - Fellow, Royal College of Nursing
- FRCNA - Fellow, Royal College of Nursing, Australia

G

- GN - Graduate Nurse (awaiting RN licensure)
- GNP - Gerontological Nurse Practitioner
- GPN - General Pediatric Nurse
- GPN - Graduate Practical Nurse
- GRN - Graduate Registered Nurse

H

- HHA - Home Health Aide
- HNC - Holistic Nurse, Certified

I

- IBCLC - International Board-Certified Lactation Consultant
- INC - Intensive Neonatal Care certification
- INPT - Inpatient obstetric nursing certification

L

- LCCE - Lamaze Certified Childbirth Educator
- LNC - Legal Nurse Consultant
- LNCC - Legal Nurse Consultant, Certified
- LPN - Licensed Practical Nurse
- LRN - Low Risk Neonatal nursing certification
- LSN - Licensed School Nurse
- LVN - Licensed Vocational Nurse

M

- MA - Master of Arts
- ME - Menopause Educator
- MICN - Mobile Intensive Care Nurse
- MN - Master of Nursing
- MN - Maternal Newborn nursing certification
- MS - Master of Science
- MSN - Master of Science in Nursing

N

- NCSN - National Certified School Nurse
- NIC - Neonatal Intensive Care nurse
- NNP - Neonatal Nurse Practitioner
- NPC - Nurse Practitioner, Certified
- NPP - Nurse Practitioner, Psychiatric

O

- OCN - Oncology Certified Nurse
- OGNP - Obstetrics & Gynecology Nurse Practitioner
- ONC - Orthopedic Nurse Certified

P

- PALS - Pediatric Advanced Life Support (not intended for postnominal use)
- PCCN - Progressive Care Certified Nurse
- PhD - Doctor of Philosophy
- PHN - Public Health Nurse
- PHRN - Pre-Hospital Registered Nurse
- PMHCNS - Psychiatric Mental Health Clinical Nurse Specialist
- PMHNP - Psychiatric Mental Health Nurse Practitioner
- PNP - Pediatric Nurse Practitioner

R

- RMN - Registered Male Nurse (unofficial designation for nurses tired of being called "male nurses" but willing to joke about it)
- RN - Registered nurse
- RN-BC - Registered Nurse, Board Certified
- RN-BSN – Registered Nurse, Bachelor of Science in Nursing
- RN-MSN – Registered Nurse, Master of Science in Nursing
- RN- PhD – Registered Nurse, Doctor of Philosophy
- RN,C - Registered Nurse, Certified: American Academy Certified Nurse
- RNC - Registered Nurse, Certified: National Certification Corporation
- RNCS - Registered Nurse Clinical Specialist
- RNCS - Registered Nurse Certified Specialist
- RNFA - Registered Nurse First Assistant
- RPN - Registered practical nurse

S

- SANE - Sexual Assault Nurse Examiner
- SEN - State Enrolled Nurse
- SN - Student Nurse (RN preparation)
- SPN - Student Nurse (LPN preparation)
- SVN - Student Nurse (LVN preparation)

T

- TNCC-I - Trauma Nursing Core Course Instructor (not intended for postnominal use)
- TNCC-P - Trauma Nursing Core Course Provider (not intended for postnominal use)
- TNP - Telephone Nursing Practitioner
- TNS - Trauma Nurse Specialist

W

- WHNP - Women's Health Nurse Practitioner
- WOCN - Wound, Ostomy, Continence Nurse
- WCC - Wound Care Certified

(Derived from: Wikipedia, 2008)

Special note: Although Wikipedia is not regarded as a reliable source for academic writings, in the case of the subject of nursing credentials, Wikipedia with its exhaustive listing and continual updates has proven to be the most current, reliable and thorough source. The American Nursing Association has referred individuals to this Wikipedia site as a comprehensive listing and overview to the profession's certification and credentialing.

Appendix F

Nurse Qualification Questionnaire

Interview Qualification Questionnaire

Thank you for your interest in our research project. This research project has been designed by the University of Texas at Austin – College of Communication to study the interaction between nurses. Please help us to determine your qualifications as a potential participant by completing the following brief questionnaire. This questionnaire will only take from 5 – 10 minutes to complete.

As we are studying interaction between nurses, you will be asked to relate a brief personal conflict topic in your nursing profession near the end of the questionnaire. If you feel uncomfortable providing this topic, or with any of the questions asked, you may exit this survey at any time and any data that you listed or proved will be permanently deleted.

Also, any and all information that you submit is held in strict confidentiality.

At the end of the questionnaire you will be asked for a current email address to be notified of participation. This is important as all initial contacts are made via email. If you are selected, you will be entitled to a $50.00 gift card to either Macy's of Shell Oil that will be given to you at the completion of the face-to-face interview.

Thank you again for your interest.

1. **First name: _____**
2. **Initial of last name: _____**
3. **Age**: _____
4. **Gender**:
   - o Male
   - o Female
5. **Marital Status:**
   - o Married
   - o Single
   - o Divorced
   - o Widowed
6. **Children:**
   - o Yes - #____
   - o No
7. **Race**:

- Caucasian (European-American)
- Hispanic
- African-American
- Native American
- Asian
- Middle Eastern
- Other – Please specify: _____

8. **Education** – What is your highest level of education?
   - High School Diploma or GED
   - Diploma Nurse
   - Some College
   - Associate Degree
   - Bachelor's Degree
   - Some Graduate Work
   - Master's Degree
   - Doctorate Degree
9. **Military** - Have you served in the Military? _____
10. **Licensing and Certification** – Please list ***all*** of your current licenses and certifications (example: RN, LVN, CNA, CMA, NP, APRN, CCM, etc…):

    _____

    _____

    _____

    _____

    _____

11. **Employment** - At what age did you enter the health care profession? _____

    Become a RN? _____
12. Are you currently employed as a nurse? _____
13. How many hours do you work in a week on the average? _____
14. What is your employment status (check all that applies)?
    - Full time
    - Part time
    - Contract
    - Seasonal
    - PRN
    - Other
15. What is your current employer?
    - Hospital or medical center
    - Physician's office or clinic

- Rehabilitation facility
- Long-term care facility
- Home Health organization
- Hospice
- Public or private school
- Corporate organization
- Church or parish
- Other

16. **Salary** – What is your salary range as a nurse?
    - Under $15,000
    - $15,000 - $24,000
    - $25,000 - $34,000
    - $35,000 - $44,000
    - $45,000 - $59,000
    - $60,000 - $74,000
    - Over $75,000
    - Other
17. **Organizational tenure** - How long have you been employed with your current employer?
    _____ year(s) or _____ month(s)
18. **Group tenure** – How long have you been in your current position?
    _____ year(s) or _____ month(s)

19. **Position** – Please describe your current position:

    _____
    _____
    _____
    _____
    _____

20. **Function** – Please describe your function in your current position:

    -

    _____
    _____
    _____
    _____
    _____

21. Do you interact daily with other RNs, LVNs or MA (Med techs)? _____

If yes, approximately how many of each? _____

22. This research study investigates interactions between nurses. In the space below, can you provide a topic and brief explanation of a conflict that you have experienced either recently or in the past with another nurse?

_____

_____

_____

_____

_____

Appendix G

Nursing Solicitation Flyer

Appendix H

Interview Questions

1. Do you find it challenging and/or enjoyable to work with different nurses in a healthcare setting?.... why, and how?
2. I want to collect stories of nursing interaction between nurses. Can you tell me what makes a good nurse? Is there a story to tell?
3. If this is a good nurse, what would be an example of a bad or problem nurse? Is there a story to tell?
4. Can you tell me a memorable story of conflict in a nurse to nurse interaction?
5. Can you tell me additional stories of nursing conflict between nurses?
6. Are there any recent conflict events that you can recall?
7. How did these events affect you?
8. How do you feel these conflict affect you emotionally?.....mentally?.....physically?
9. What do you think are the top sources of friction or conflict in nurse to nurse interaction?
10. Looking at the chart [shown below], how do you describe yourself in a conflict?....number your top three… and why do you feel you act this way?
11. Do you think these characteristics describe how you handle conflict?

HOW YOU ACT

[ ] Apologies – and takes blame
[ ] Avoid
[ ] Compromise by give and take
[ ] Confronts and explains
[ ] Consider others – inquires and questions
[ ] Defend self
[ ] Wants everyone to be happy and to look good
[ ] Expresses feelings
[ ] Gives in and accommodates
[ ] Involves third party
[ ] Ignore situation all together
[ ] Tries to control the situation
[ ] Hides or pretends that conflict doesn't exist
[ ] Discusses problem and solution
[ ] Passive or will take later action

Appendix I

Pilot Study Narratives

Rachel –

Rachel is an emergency room charge nurse at the largest hospital in the city. She has been on the job for only two years after acquiring her RN and graduating from a major research university with her BSN. She is between 23 and 26 years of age. Her staff is primarily other RNs and medical techs. Her vision of intergenerational conflict is based in her phrase: "They don't want the hours and the hard work with little staff….so they leave it to us [the younger nurses]." Rachel is not bitter, as she enjoys the fast pace and the extra money; however, she feels like she was thrown quickly into the role of charge nurse without a conventional level of experience. She contributes the promotion to charge nurse as 'the nature of the emergency room hours, degree of workload, level of stress and lack of support in medical personnel in the ER.' Rachel appears to be using credentialing as a face protection mode when approaching conflict with her coworkers (though she did not call it credentialing but rather 'the explanation of my position'). When conflict occurs Rachel will remind the other staff member, within the same or within different generation, that 'she was placed in this position because no one else would take it'. Digging deeper, Rachel explains that most of the other nurses relate to her comments knowing that they had had the position before and were glad to forsake the position of authority for less responsibilities. This was realized more in the older generations than in the younger who had not experienced the position of charge nurse. From Rachel's comment, the increase in compensation did not reflect the accolade of the charge nurse position for the older nurses. Therefore, the position was a 'thankless position' that was

past to any nurse who would take on the responsibility. For this reason, Rachel expressed that she did not see a reason to worry about saving her own, feeling that her position (as in credentialing) sufficed for the interaction.

Julie –

Julie is a day surgery RN at a large metropolitan acute care hospital. She has been employed with the same hospital for 20+ years in various nursing positions and departments. Julie is in her late 40s and has worked with several generations of nurses over the years. Her explanation of generational conflict is the comment that "the young nurses, and the new nurses just don't want to pay their dues to get the good shifts and hours. They all want the weekends off…and they expect them off the very first day they start working. I like working with them, but they need to pay their dues". Julie was not timid or reserved in her comments. She volunteered it freely… from recently having an exchange with a younger nurse earlier in the week. Julie explained that she frequently had to explain to the younger nurses why they had to work the undesirable shifts, just like she had when she started in nursing. She explained to the interviewer that she had found herself using phrases as: "I believe you have only worked one weekend this month" and "there was a time when the new nurses would have to work all the weekend shifts." In both cases Julie appeared to be using disclaimers (cognitive and credentialing) to communicate a defensive face tactic. Julie felt that restorative face (as in how she would restore her own face if damaged by the interaction) was always best handled by a mode of justification: "they needed to be told and I would explain it to them" or "someone just needs to tell them". Both of the restorative practices were easy for Julie to enact. She had no remorse or regret in the way she approached the younger nurses. In her mind, she was

doing a favor for all parties, herself, the young nurses, and the other seasoned nurses that often would not speak up for themselves.

Rose –

Rose was a med-surg nurse at a large metropolitan acute care hospital. She was nearing 60 and had entered nursing as a second career in her mid 30s. Rose had started as a diploma RN, but then pursued a BSN ten years later. Within the last five years Rose had completed her MSN and was now considered a nurse preceptor, a senior nurse that assists and mentors new nurses to the facility. As a preceptor Rose had a different view of the young nurses. She explained that she had attended nursing school as a mid 40 year old, learning beside 20 year old students. In the MSN program Rose found herself supervising new undergraduates GNs awaiting their RN certification. These two conditions resulted in Rose' explanation that: "the younger nurses are really good…and in many ways better that us old ones. I especially like the ones that come from the community college vocational training. They get more hands-on experience and ready to hit the floor running. But you can't undervalue those that come out of UT. They know their stuff, but just don't know yet how to use it." Rose elaborated that conflicts were few for her since she basically attempted to avoid them. "I leave it to the charge nurse if there's a problem. Besides, within a year I plan on retiring and going to teach at the college. I really like working and helping new nurses." When questioned about defensive face practices Rose simply answered: "I just try to be polite and explain the issue and why we do it the way we do. I really want them to understand why we do what we do and how it can affect the patient. Especially I do not want to discourage them. You don't get anything accomplished by being mean or unpleasant. They'll just get defensive and will stop

listening. I have people do that to me." Rose continued, "If they don't understand or don't agree, I usually will back off and just ask the charge nurse to take over. It's not that I don't want to be the bad guy, it's that I don't want to start an episode on the floor." From her comments Rose had explained that her nature was to confront politely by enlisting politeness as part of her defensive face practice; however, as restorative, Rose would become an avoidant and flee the situation to avoid continual or future conflict. Ironically, for a person that mentors and desires to teach nurses, Rose maintained an interesting avoidant nature.

The Analysis and conclusions –

From the analysis of the above interviews, I have reached the following tentative conclusions:

Rachel's position is that she is being left to take on jobs that older generations no longer desire. Her comment that she was "placed in the position because no one else would take it" signified that, in her mind, this was older nurses dumping their responsibilities on younger ones. She does not reflect anger but rather a sense of factual knowledge that the older generations leave it for the 'younger', and the younger 'realize it'. Credentialing and justification is Rachel's tactic for managing face**.** In credentialing, Rachel says to herself that the responsibility is now hers. It is her job, her position and, like it or not, her responsibility. The buck stops with her. Rachel's facework in justification reflects a different posture. Here, she is communicating that, to remain credible with others, she needs to fulfill the action and responsibility "dumped" on her. This becomes both an appeal to her own face and an appeal to her value to others. Of course, Rachel could have resisted the position but her justification reflects her personal appeal to self-fulfillment—"I really like doing this," or "I want to be in charge."

In contrast, Julie exhibits a level of anger. Her anger is related to the concept of 'paying one's dues'. Several times her statements are directly linked to telling the younger nurses what to do and how to do it, justifying the exchange by noting that 'dues payment' is part of the profession. Julie, like Rachel, incorporates credentialing (stating her past actions) and justification in her face management. Julie's justification is clearly a principle of retribution, "I did it, now they need to do it." Julie also appeals to value in her justification. She states that it is the right thing to do—to tell them their responsibility. Julie stops just short of labeling through the use of personal idioms. I was waiting for her to say that the "newbies" are "spoiled and rotten". She made have responded this way to her fellow age nurses but most likely would hold her comments when talking to a visitor like myself.

Lastly is Rose, patient and nurturing. As a mentor and nurse preceptor, she has a different view of the younger nurses. She sees value and potential in them. Unlike Julie, she feels little threat or encroachment. Rose, by her own admission, avoids confrontation as a face tactic and implies that discouragement should be avoided. From a simple comparison of these three nurses, the middle-age nurse appears the most threatened. Perhaps due to her age, she intends to work in the profession for several more years. This is apparent in her 'paying your dues' comment. The older nurse, nearing retirement, recognizes the younger nurses for their potential and ability, much like a grandparent may see potential in their grandchildren. The younger nurse recognizes that she is getting the "leftovers" or undesired job(s). She remains positive and upbeat to some extent but her responses show signs of animosity toward the older generations.

Another theme surfacing during the interviews was the concept of appreciation for other generations as it relates to length of service. Rose, the older nurse, is a mid-life,

second-career nurse who is polite and appreciative of other nurses who were trained young. Julie, the middle-age nurse, was trained young and has been a career nurse from the beginning. She takes her professional standing very seriously, scrutinizing the work of the younger nurses and showing a reduced appreciation of them. Rachel, a newly trained and licensed nurse, may or may not be a career nurse. Already, she recognizes that she is 'low man' for duties even though her title places her above older nurses. She is brazen with her supervisory role but has developed an attitude that 'I'm stuck with it'. These analyses could conclude that mid-life, second-career nurses are more positive and appreciative of younger nurses. To the contrary, life-long career nurses are less understanding and possibly indignant toward the younger nurses. Interestingly, both the young nurse and the life-long nurse use credentialing and justification as their face tactic. However, in analyzing such a small dataset, it was impossible to conclude that specific facework or face tactics are unique to certain conditions, age groups or career positions. It would require a lengthier and more probing interview to determine relationships and patterns. That said, it was interesting to see how these pilot-interview findings were to some extent replicated in the full research-study, reflecting a connection between facework and conflict style.

Appendix J

IRB Participant Consent Form

IRB APPROVED ON: 03/07/2011 ***EXPIRES ON: 03/06/2012***

Research Title: The role of face saving facework negotiation tactics within nursing conflict

IRB PROTOCOL # 2008-09-0121
Conducted By: Randolph Wilt
Of University of Texas at Austin:
Department / Office: Communications Studies
Telephone: 512-471-5251 (Dept. office) 512-380-7979 (Direct)

You are being asked to participate in a research study. This form provides you with information about the study. The person in charge of this research will also describe this study to you and answer all of your questions. Please read the information below and ask any questions you might have before deciding whether or not to take part. Your participation is entirely voluntary. You can refuse to participate without penalty or loss of benefits to which you are otherwise entitled. You can stop your participation at any time and your refusal will not impact current or future relationships with UT Austin or participating sites. To do so simply tell the researcher you wish to stop participation. The researcher will provide you with a copy of this consent for your records.

The purpose of this study is to study organizational stories of intergenerational conflict between nurses of different generations and how protective and restorative facework can affect the outcome and how the face act can be categorized thematically and provide a better understanding of generational conflict.

If you agree to be in this study, we will ask you to do the following things:

- Participate in an audio recorded interview about any past experiences in reversed organizational bullying and how these experiences may or may not have affected other employees/workgroups.

Total estimated time to participate in study is 60-90 minutes

Risks of being in the study

- This interview, due to the topic matter, may reawaken personal memories; however, there is no anticipated risk of harm greater than that encountered in daily life. Although you, as the participant, may decline to answer any questions, it is possible that you may experience some psychological discomfort at the content of the interview. If you wish to discuss the information above, you may ask questions now or call the Principal Investigator listed on the front page of this form. If you would like additional information about psychological issues, you may wish to contact the Austin Travis County MHMR-Behavioral Health Services at 512-472-4357 and inquire about their services that addresses the psychological health of the whole person by maximizing the resources of the MHMR.

Benefits: The benefit that you, the participation, may realize from this study is the ability to better understand and recognize your own conflict behavior style when approaching an intergenerational conflict requiring face-saving tactics. Though the job of the researcher is not to coach the participant on personal behavior style, the process of the interview can provide insights for you to see how a past conflict interaction can be viewed through a lens of face-saving tactics. If desire the researcher can also provide you with the research results upon completion of the research.

Compensation: A $50.00 gift card

Confidentiality and Privacy Protections:

- Regarding all data collected, the interview will be audio taped.
- No use of your specific full name, employee names, or the name of your organization will be included in the research report.
- All audio interviews will be transcribed without mention of your name or that of your organization or employees. You and your organization will be referred to by a fictitious name designed by either you, or the researcher. Specifically the audio cassette will be coded so that no personally identifying information will be visible on them.

- The data resulting from your participation may be made available to other researchers in the future for research purposes not detailed within this consent form; however, the data and tapes will only be heard or viewed for research purposes by the investigator and his associates.
- All tapes and data from the study will be maintained in secure files. Due to the scope of the study future review of the tapes may become necessary. For this reason the audio may not immediately be erased after the transcription period, but securely maintained for future review. Any future use of the tapes will only be for research purposes and not for presentation or educational purposes.

The records of this study will be stored securely and kept confidential. Authorized persons from The University of Texas at Austin, members of the Institutional Review Board, and (study sponsors, if any) have the legal right to review your research records and will protect the confidentiality of those records to the extent permitted by law. All publications will exclude any information that will make it possible to identify you as a subject. Throughout the study, the researchers will notify you of new information that may become available and that might affect your decision to remain in the study.

Contacts and Questions:

If you have any questions about the study please ask now. If you have questions later, want additional information, or wish to withdraw your participation, please call the researchers conducting the study. Their names, phone numbers, and e-mail addresses are at the top of this page.

If you have questions about your rights as a research participant, complaints, concerns, or questions about the research please contact Jody Jensen, Ph.D., Chair of The University of Texas at Austin Institutional Review Board for the Protection of Human Subjects at (512) 232-2685 or the Office of Research Compliance and Support at (512) 471-8871 or email: orsc@uts.cc.utexas.edu.

You will be given a copy of this information to keep for your records.

Statement of Consent:

I have read the above information and have sufficient information to make a decision about participating in this study. I consent to participate in the study.

Signature:_____ Date: _____

_____ Date: _____
Signature of Person Obtaining Consent

Signature of Investigator:_____ Date: _____

OFFICE OF RESEARCH SUPPORT

THE UNIVERSITY OF TEXAS AT AUSTIN

P.O. Box 7426, Austin, Texas 78713 (512) 471-8871 -FAX (512 471-8873)
North Office Building A, Suite 5.200 (Mail code A3200)

FWA # 00002030

Date: **02/11/11**

PI(s): **Randolph R Wilt** Department & Mail Code: **DEPT OF COMMUNICATION ST A1105**

Title: **The role of face saving facework negotiation tactics within nursing conflict**

IRB EXPEDITED CONTINUING REVIEW APPROVAL: IRB Protocol # **2008-09-0121**

Dear: **Randolph R Wilt**

In accordance with the Federal Regulations the Institutional Review Board (IRB) reviewed the continuing review report for the above referenced research study and found it met the requirements for approval under the Expedited category noted below for the following period of time:
03/07/2011 - 03/06/2012 . *Expires 12 a.m. [midnight] of this date.*

Expedited category continuing review approval:

☐ **(1)** Clinical studies of drugs and medical devices only when condition (a) or (b) is met. (a) Research on drugs for which an investigational new drug application (21 CFR Part 312) is not required. (Note: Research on marketed drugs that significantly increases the risks or decreases the acceptability of the risks associated with the use of the product is not eligible for expedited review). (b) Research on medical devices for which (i) an investigational device exemption application (21 CFR Part 812) is not required; or (ii) the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.

☐ **(2)** Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows: (a) from healthy, non-pregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8 week period and collection may not occur more frequently than 2 times per week; or (b) from other adults and children2, considering the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected. For these subjects, the amount drawn may not exceed the lesser of 50 ml or 3 ml per kg in an 8 week period and collection may not occur more frequently than 2 times per week.

☐ **(3)** Prospective collection of biological specimens for research purposes by Non-invasive means.
Ex
(a) hair and nail clippings in a non-disfiguring manner;

(b) deciduous teeth at time of exfoliation or if routine patient care indicates a need for extraction;
(c) permanent teeth if routine patient care indicates a need for extraction;
(d) excreta and external secretions (including sweat);
(e) uncannulated saliva collected either in an un-stimulated fashion or stimulated by chewing gumbase or wax or by applying a dilute citric solution to the tongue;
(f) placenta removed at delivery;
(g) amniotic fluid obtained at the time of rupture of the membrane prior to or during labor;
(h) supra- and subgingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic scaling of the teeth and the Process is accomplished in accordance with accepted prophylactic techniques;
(i) mucosal and skin cells collected by buccal scraping or swab, skin swab, or mouth washings;
(j) sputum collected after saline mist nebulization.

☐ **(4)** Collection of data through noninvasive procedures (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. Where medical devices are employed, they must be cleared/approved for marketing. (Studies intended to evaluate the safety and effectiveness of the medical device are not generally eligible for expedited review, including studies of cleared medical devices for new indications).
Examples:
(a) physical sensors that are applied either to the surface of the body or at a distance and do not involve input of significant amounts of energy into the subject or an invasion of the subject's privacy;
(b) weighing or testing sensory acuity;
(c) magnetic resonance imaging;
(d) electrocardiography, electroencephalography, thermography, detection of naturally occurring radioactivity, electroretinography, ultrasound, diagnostic infrared imaging, doppler blood flow, and echocardiography;
(e) moderate exercise, muscular strength testing, body composition assessment, and flexibility testing where appropriate given the age, weight, and health of the individual.

☐ **(5)** Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for non-research purposes (such as medical treatment or diagnosis). (NOTE: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45 CFR 46.101(b)(4). This listing refers only to research that is not exempt).

☒ **(6)** Collection of data from voice, video, digital, or image recordings made for research purposes.

☒ **(7)** Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. (NOTE: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45 CFR 46.101(b)(2) and (b)(3). This listing refers only to research that is not exempt).

☒ Use the attached approved informed consent.

☐ You have been granted a Waiver of Documentation of Consent according to 45 CFR 46.117 and/or 21 CFR 56.109(c)(1).

☐ You have been granted a Waiver of Informed Consent according to 45 CFR 46.116(d).

Responsibilities of the Principal Investigator:

1. Report immediately to the IRB any unanticipated problems.

2. Ensure the proposed changes in the approved research during the IRB approval period will not be applied without IRB review and approval, except when necessary to eliminate apparent immediate hazards to the subject. Changes in approved research implemented without IRB review and approval initiated to eliminate apparent immediate hazards to the subject must be promptly reported to the IRB, and will be reviewed under the unanticipated problems policy to determine whether the change was consistent with ensuring the subjects continued welfare.

3. Report any significant findings that become known in the course of the research that might affect the willingness of subjects to continue to participate.

4. Ensure that only persons formally approved by the IRB enroll subjects.

5. Use only a currently approved consent form (remember that approval periods are for 12 months or less).

6. Protect the confidentiality of all persons and personally identifiable data, and train your staff and collaborators on policies and procedures for ensuring the privacy and confidentiality of subjects and their information.

7. Submit for review and approval by the IRB all modifications to the protocol or consent form(s) prior to the implementation of the change.

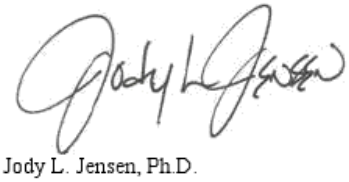
8. Submit a Continuing Review Application for continuing review by the IRB. Federal regulations require IRB review of on-going projects no less than once a year (a Continuing Review Application and a reminder letter will be sent to you two months before your expiration date). If a reminder is not received from Office of Research Support (ORS) about your upcoming continuing review, it is still the primary responsibility of the Principal Investigator not to conduct research activities on or after the expiration date. The Continuing Review Application must be submitted, reviewed and approved, before the expiration date.

9. Upon completion of the research study, a Closure Report must be submitted to the ORS.

10. Include the IRB study number on all future correspondence relating to this protocol.

If you have any questions call or contact the ORS (Mail Code A3200) or via e-mail at orsc@uts.cc.utexas.edu.

Sincerely,



Jody L. Jensen, Ph.D.
Professor
Chair, Institutional Review Board

Appendix K

Section 301.452 Grounds for Disciplinary Action

Sec. 301.452. Grounds for Disciplinary Action.

(a) In this section, "intemperate use" includes practicing nursing or being on duty or on call while under the influence of alcohol or drugs.

(b) A person is subject to denial of a license or to disciplinary action under this subchapter for:

(1) a violation of this chapter, a rule or regulation not inconsistent with this chapter, or an order issued under this chapter;

(2) fraud or deceit in procuring or attempting to procure a license to practice professional nursing or vocational nursing;

(3) a conviction for, or placement on deferred adjudication community supervision or deferred disposition for, a felony or for a misdemeanor involving moral turpitude;

(4) conduct that results in the revocation of probation imposed because of conviction for a felony or for a misdemeanor involving moral turpitude;

(5) use of a nursing license, diploma, or permit, or the transcript of such a document, that has been fraudulently purchased, issued, counterfeited, or materially altered;

(6) impersonating or acting as a proxy for another person in the licensing examination required under Section 301.253 or 301.255;

(7) directly or indirectly aiding or abetting an unlicensed person in connection with the unauthorized practice of nursing;

(8) revocation, suspension, or denial of, or any other action relating to, the person's license or privilege to practice nursing in another jurisdiction;

(9) intemperate use of alcohol or drugs that the Board determines endangers or could endanger a patient;

(10) unprofessional or dishonorable conduct that, in the board's opinion, is likely to deceive, defraud, or injure a patient or the public;

(11) adjudication of mental incompetency;

(12) lack of fitness to practice because of a mental or physical health condition that could result in injury to a patient or the public; or

(13) failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that, in the Board's opinion, exposes a patient or other person unnecessarily to risk of harm.

(c) The Board may refuse to admit a person to a licensing examination for a ground described under Subsection (b).

(d) The Board by rule shall establish guidelines to ensure that any arrest information, in particular information on arrests in which criminal action was not proven or charges were not filed or adjudicated, that is received by the board under this section is used consistently, fairly, and only to the extent the underlying conduct relates to the practice of nursing.

From: http://www.bon.state.tx.us/nursinglaw/npa1.html

Appendix L

New face tactics discovered with supporting excerpts

1. *Defensive – Competitive – Halting statement*

   "I was like, 'you cannot talk to me this way'. And that stopped it." Janice

2. *Defensive – Competitive –Enlisting disclaimers –Soliciting others (or appeal to authority)*

   "I'm bad like for my passive-aggressive way, because I'll…I'll probably call the Rank Nurse." Helen

3. *Defensive – Competitive –Blocking goals – Opposite and oppositional*

   "She's the only person I've ever met that everybody called her Miss Hull. So, everybody had some respect for her. Even though she was the worst nurse I've ever met in my whole, entire life, yet, she had been at this hospital since like it opened. And finally one day she was like, 'I really don't like it that you call me by my last name.' [It was] too bad, nobody wanted to [call her by her first name]. Everybody wanted to call her Miss Hull." Janice

4. *Defensive – Competitive – Competitive acts – Taking credit and self-appreciation:*

   "I think the best way to handle conflict…be honest and just make myself look good." Ashley

5. *Defensive – Competitive –Response – Un-demonizing*

   "[The assigning nurse] 'she's not inexperienced, she's been a nurse for ten years and she's not on orientation.' She was like, 'it's not that she doesn't want to do it. She just got out of two others, and she's still behind on her paper work…she wasn't trying to push it off on you.'" Jasmine

6. *Defensive – Competitive –Responses – Returning question or statement*

"And, I said, 'that doesn't mean anything. Pressure means nothing, especially on our unit, we only check vital signs, and blood pressure, and pulse every four hours. So what you're telling me is, you don't know what happened overnight.'" Patti

7. *Defensive – Enlisting Politeness – Sarcastic Politeness*

   "I was like, 'okay, I respect you. You're great. I respect you. You're great.'" Janice

8. *Restorative – Accommodative – Accustom or understanding other.*

   "We just kind of grown accustom to each other." Jacob

9. *Restorative – Accommodative - Apologies – Unconditional*

   "I tried for a day to call her - - her first name. It was like something normal, like Ann. But no - - and I tried, and I couldn't do it. I was like, 'you know, Ms. Hull, I really - - I tried, and I just couldn't.'" Janice

10. *Restorative – Compromise – Sidetracking with alternatives*

    "So, I try to find other ways, by being like, 'okay, you know, tell me this story, like after I'm done calling these patients, or doing this.'" Sarah

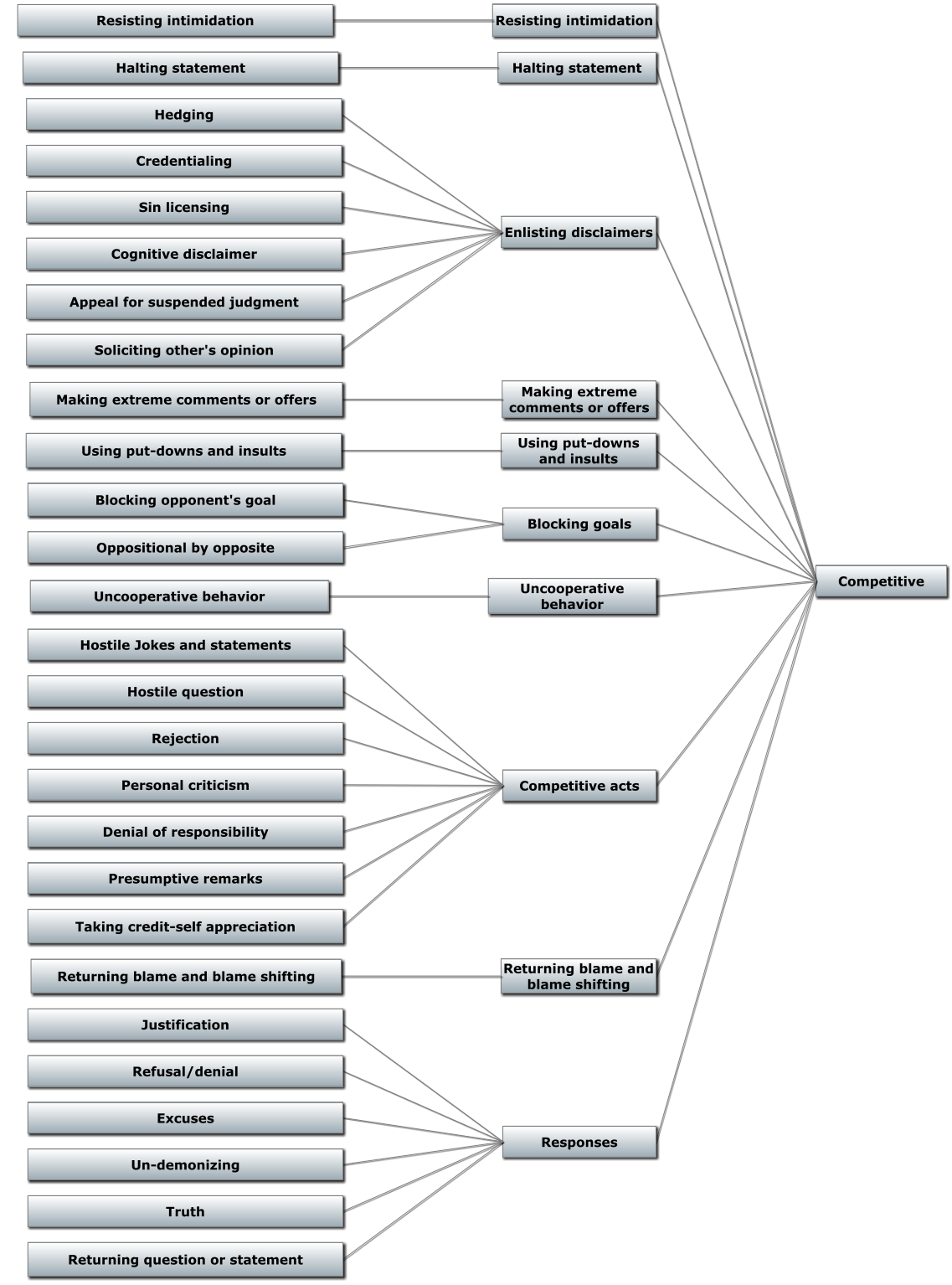
11. *Restorative – Collaborate – Accounts – Storytelling and analogies*

    "I just think she just assumes I'm a new grad…and I've tried to remind her, 'yes, I used to run a plastic surgery practice. I would tell her.'" Karla J.

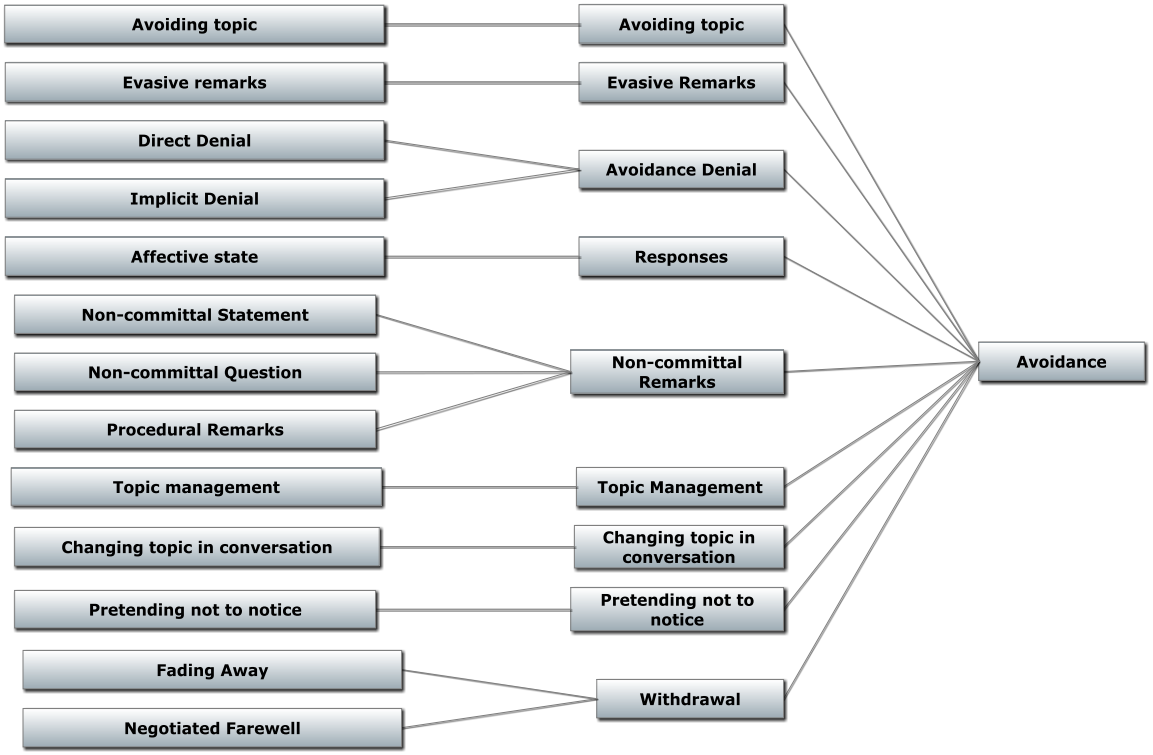
Appendix M

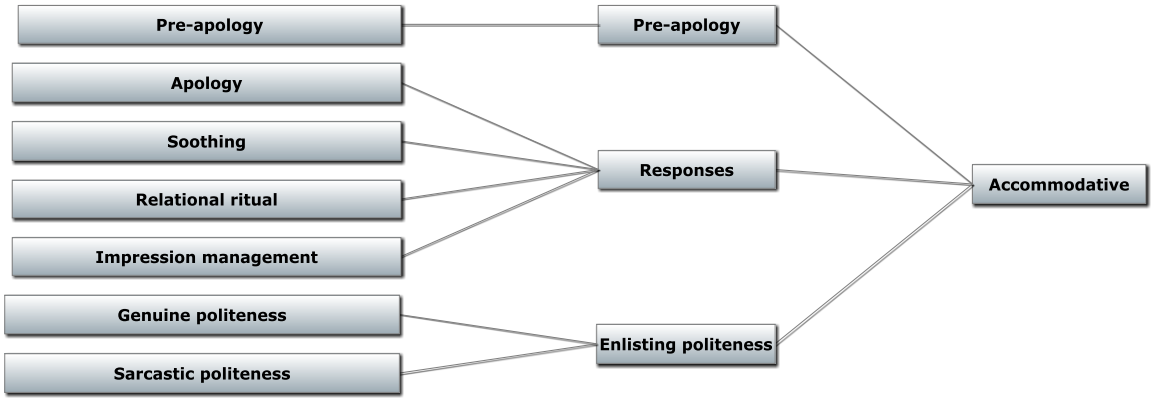
Defensive face tactic decision tree

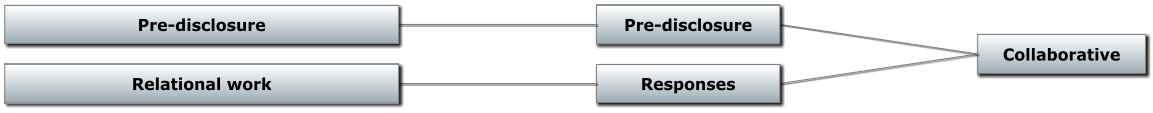
Defensive



Defensive – continued



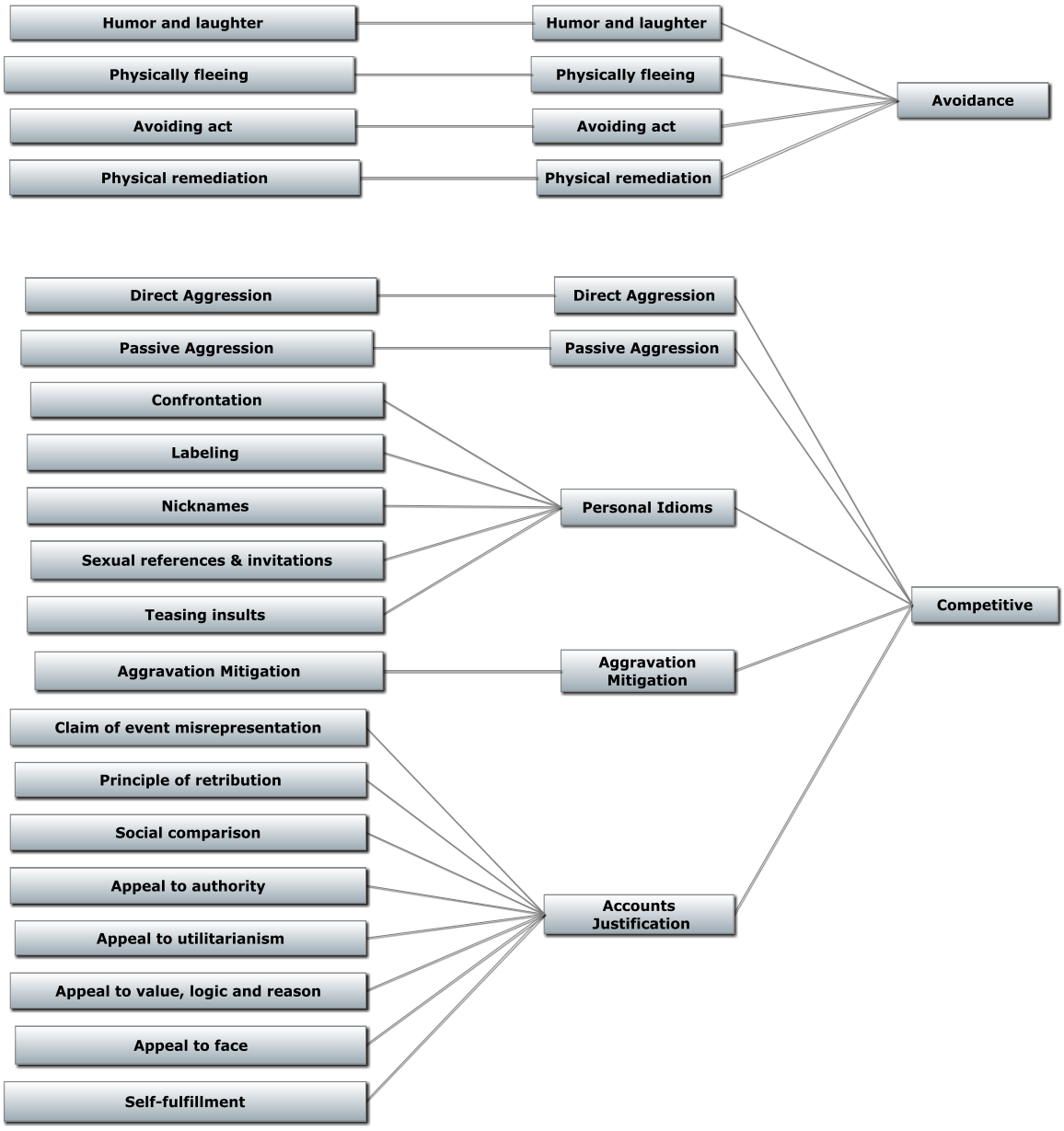




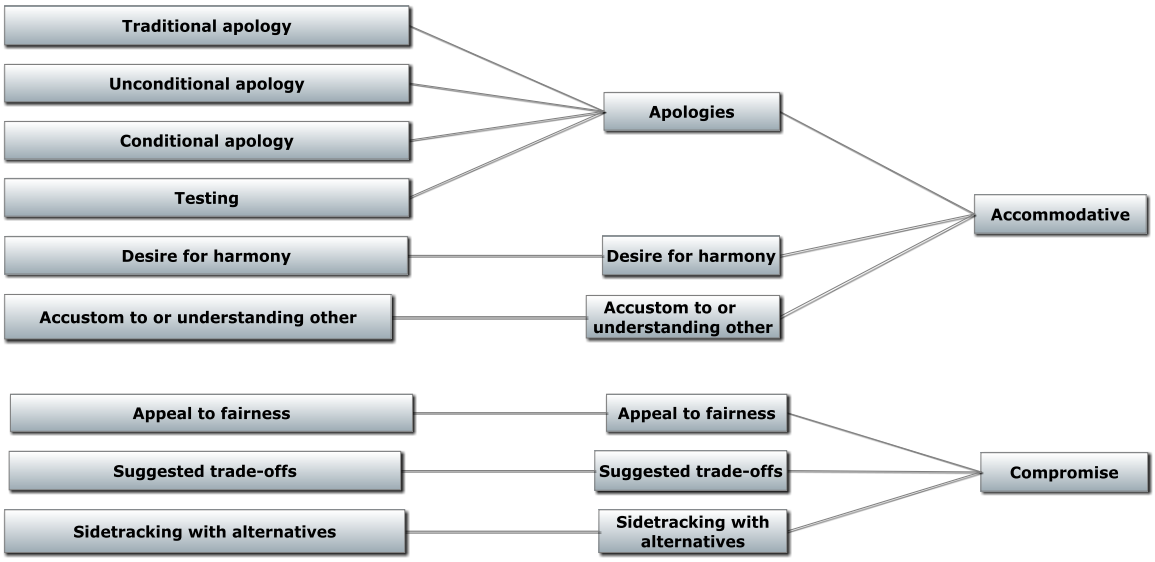
Appendix N

Restorative face tactic decision tree

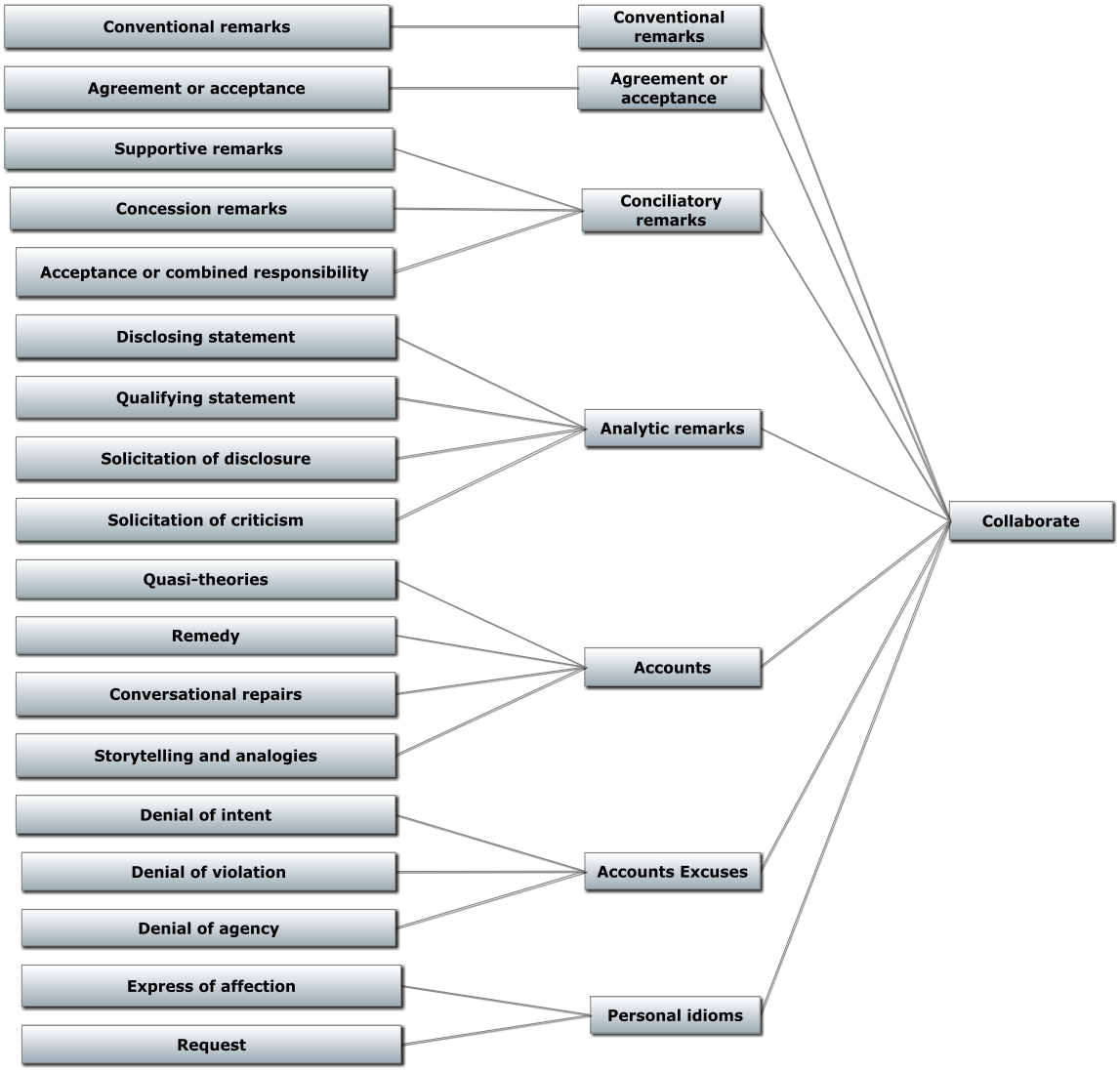
Restorative



Restorative – continued



Restorative – continued



Appendix O

Revised face tactics from the literature with addition of new tactics

Defensive (Protective) Practices	Explanation/Example	Reference
A. AVOIDANCE		
1. Avoiding topics	"Let's talk about it later" "I don't think we should discuss it at the moment"	Cupach and Metts, 1994
2. Evasive Remarks	"That could be the case"	Sillars, 1986
3. Avoidance Denial – Direct denial	"That's not my problem"	Sillars, 1986
4. Avoidance Denial – Implicit denial	"That's never been a problem before"	Sillars, 1986
5. Responses – Affective state	Crying, running away, pouting and other visible states	Cupach and Metts, 1994
6. Non-Committal Remarks – Non-committal statement	"So what's the big deal"	Sillars, 1986
7. Non-Committal Remarks – Non-committal question	"So what do you think?" or "I don't understand what you are saying"	Sillars, 1986
8. Non-Committal Remarks - Procedural remarks	"You're not speaking loudly enough" or "Can you say it again so that I can understand you"	Sillars, 1986
9. Topic Management	"What about this too?"	Sillars, 1986
10. Changing topic or subject in conversation	Stream shifting "Yes, but I remember a time….."	Cupach and Metts, 1994
11. Pretending to not notice when something FT is done	"Did you say something?"	Cupach and Metts, 1994
12. Withdrawal – Fading Away (Indirect)	Slowly disappearing from the scene or the conflict interaction	Cupach and Metts, 1994
13. Withdrawal – Negotiated Farewell (Direct)	Termination of relationship or contact. "I think it is time for me to leave" or "If you feel that way, I'll just go away."	Cupach and Metts, 1994

B.	**COMPETITIVE**		
	14. Resisting intimidation	"Don't try to put it on me."	Folger, Poole & Stutman, 1997
	15. Halting statement	Comments that stops the discussion for clarification, justification or interaction or emotion management "Stop! Let's address this first" or "Hold it! Before you go any further let consider this" or "Wait! Everyone just needs to settle down."	
	16. Enlisting disclaimers – Hedging	"I may be wrong" or "could it be this instead?"	Hewitt and Stokes, 1975
	17. Enlisting disclaimers – Credentialing	Stating one's status - "I have years of experience in …"	Hewitt and Stokes, 1975
	18. Enlisting disclaimers – Sin licensing	Indicating that is an acceptable behavior "But everyone is doing it!"	Hewitt and Stokes, 1975
	19. Enlisting disclaimers – Cognitive disclaimer	Indicating knowledge of unreasonable behavior "I know, but it is acceptable"	Hewitt and Stokes, 1975
	20. Enlisting disclaimers – Appeal for suspended judgment	"Hear me out before deciding"	Hewitt and Stokes, 1975
	21. Enlisting disclaimers – Soliciting other's opinion	"Maybe, but let's ask the boss."	
	22. Making extreme offers or comments	"Fine. I'll just do it myself"	Wilson, 1992
	23. Using put-downs, insults, degrading comments or threats	"I'll just take care of it since you obviously can't"	Tjosvold, 1974
	24. Blocking goals – Blocking opponent's goals	"You wait for me before you do anything" "My way comes first!"	Tjosvold, 1977a, 1977b
	25. Blocking goals – Oppositional by opposite	"I know you don't want to hire her, so I'm going to hire her anyway." or "Time is critical to you, but I'm going to take my time."	

26. Uncooperative behavior	"Maybe later when I feel like it"	Tjosvold, 1977a, 1977b; Cupach and Metts, 1994; Wilson, 1992
27. Competitive Acts – Hostile Jokes and statements	"So what are you really trying to say?"	Sillars, 1986
28. Competitive Acts – Hostile Question	"Who made you perfect" or "So who made you the goddess"	Sillars, 1986
29. Competitive Acts – Rejection	"Oh, come on" or "You're exaggerating"	Sillars, 1986
30. Competitive Acts – Personal Criticism	"Who are you to criticize me"	Sillars, 1986
31. Competitive Acts – Denial of Responsibility	"That's not my fault"	Sillars, 1986
32. Competitive Acts – Presumptive Remarks	"Just get over it"	Sillars, 1986
33. Competitive Acts – Taking credit and self-appreciation	"They said I'm the best" or "Everyone knows I do the best work"	
34. Returning blame and blame shifting	"Maybe I did, but you did it too" or "Do you know what he did?"	Similar to Passive Aggression from Ting-Toomey, 2005
35. Responses – Justification	"This is the way I was taught to do it" or "no one else could do it."	Cupach and Metts, 1994
36. Responses – Refusal/denial	"I didn't do it"	Cupach and Metts, 1994
37. Responses – Excuses	"I didn't know that it was wrong to do that"	Cupach and Metts, 1994
38. Responses – Un-demonizing	"Everything I do, someone complains about it" or "It's not that I don't want to help you out."	
39. Responses – Truth	"I tried to be totally honest with you"	Cupach and Metts, 1994

40. Responses – Returning question or statement	Rebounding a question that there's a failure to understand "You just don't get it" or "You just don't understand me"	
C. ACCOMMODATIVE		
41. Pre-apology	"Before we start I want to mention that I …"	Ting-Toomey, 2005 Cupach and Metts, 1994
42. Responses - Apology	"I'm really sorry I did that"	Cupach and Metts, 1994
43. Responses - Soothing	"Yes, you have every right to be angry"	Cupach and Metts, 1994
44. Responses - Relational Ritual	Flowers, cakes or other gifts	Cupach and Metts, 1994
45. Responses – Impression Management	"You're not even close"	Cupach and Metts, 1994
46. Enlisting politeness – Genuine politeness	Using polite comments and gestures. Offering credibility	Brown and Levinson, 1987
47. Enlisting politeness – Sarcastic politeness	"Yeah, I'm like really, really sorry!"	
D. COLLABORATIVE		
48. Pre-disclosure	Bonding statement - "We're in this together"	Ting-Toomey, 2005 Cupach and Metts, 1994
49. Responses – Relational Work	A sense of hope."I think we can work this out"	Cupach and Metts, 1994
Restorative (Corrective) Practices	Explanation/Example	Reference
A. AVOIDANCE		
50. Humor and Laughter	Laughing, irony or humor	Argyle et al., 1981
51. Physically fleeing	Removing self from the situation	Cupach and Metts, 1994
52. Avoiding act	Avoiding the further discussion of the act "I need to handle this first…I'll think about it"	Ting-Toomey, 2005 Cupach and Metts, 1994
53. Physical remediation	Adjusting clothes, cleaning up, etc…	Metts and Cupach, 1989; Semin and Manstead, 1982

B.	**COMPETITIVE**		
	54. Direct Aggression	Physical violence, screaming and yelling "Just stop it!"	Ting-Toomey, 2005 Cupach and Metts, 1994
	55. Passive Aggression	Denial, forgetfulness, acting confused, blaming, sarcasm, non-verbal actions as sulking and pouting "I don't remember that"	Ting-Toomey, 2005
	56. Aggravation-Mitigation	Threats "Don't make me get a supervisor"	Labov and Fanshel, 1977
	57. Personal Idioms - Confrontation	"I'm going out on a limb" "Whose neck is on the line anyway?" "This is nothing but a bunch of monkey business"	Bell et al., 1987
	58. Personal Idioms - Labeling	"Spoiled, rotten child" "That's so gay"	Bell et al., 1987
	59. Personal Idioms - Nicknames	"The old man" "Newbie" "Sacred cow"	Bell et al., 1987
	60. Personal Idioms – Sexual references & invitations	"You give me the tingles" "Looking good!"	Bell et al., 1987
	61. Personal Idioms - Teasing insults	"You be new to the game" "Still trying to figure it out?"	Bell et al., 1987
	62. Accounts – Justification – Claim of event misrepresentation	"That's not what happened"	Semin and Manstead, 1983
	63. Accounts – Justification - Principle of retribution	"He deserved it"	Semin and Manstead, 1983
	64. Accounts – Justification – Social comparison	"Other people do it"	Semin and Manstead, 1983
	65. Accounts – Justification – Appeal of authority	"I was told to"	Semin and Manstead, 1983
	66. Accounts – Justification – Self-fulfillment	"It made me feel good"	Semin and Manstead, 1983
	67. Accounts – Justification – Appeal to utilitarianism	"The benefit outweighed the harm"	Semin and Manstead, 1983

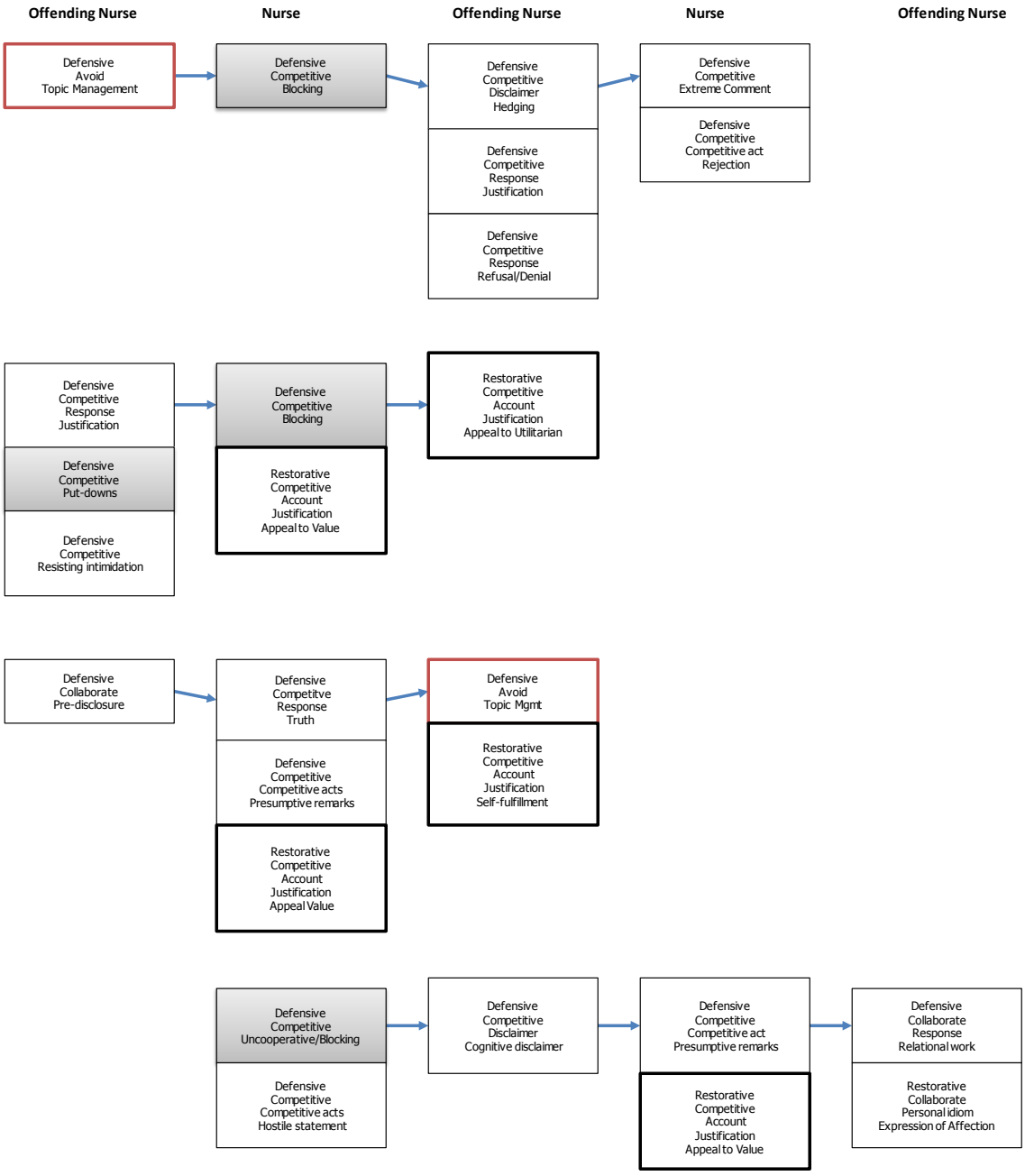
68. Accounts – Justification – Appeal to value, logic and reason	"It was the right thing to do"	Semin and Manstead, 1983
69. Accounts – Justification – Appeal to face	"I wanted to feel credible"	Semin and Manstead, 1983
C. ACCOMMODATIVE		
70. Desire for harmony	"It's OK, don't worry about it" or "It upsets me when we argue"	Sillars, 1986
71. Accustom to or understanding other	"I understand the way you feel." or "I know that is just the way you are." or "I'm used to being treated this way"	
72. Apologies - Traditional Apologies	"I'm sorry"	Goffman, 1967
73. Apologies - Unconditional	"You were right. It is all my fault."	
74. Apologies - Conditional	"I'm really sorry that I totally missed it, but you're rushing me."	
75. Apologies - Testing	"I think I entered it incorrectly. Would that be a problem?"	
D. COMPROMISE		
76. Appeal to Fairness	"You got your way last time"	Sillars, 1986 Raush, et al, 1974
77. Suggested Trade-offs	"OK, I'll do this if you do that"	Sillars, 1986
78. Sidetracking with alternatives	"I understand you're unhappy and you don't want to do it; however, how about you do this instead."	
E. COLLABORATIVE		
79. Conventional Remarks	"What do you think I did wrong?"	Raush, et al, 1974
80. Agreement or acceptance	"You're right!"	Gottman, 1979
81. Conciliatory Remarks - Supportive Remarks	"I can see why you're upset"	Sillars, 1986
82. Conciliatory Remarks - Concession Remarks	"I will do better next time"	Sillars, 1986
83. Conciliatory Remarks - Acceptance of combined responsibility	"I think we both contributed to the problem"	Sillars, 1986

84. Analytic Remarks – Disclosing statement	"I was really having a bad day	Sillars, 1986
85. Analytic Remarks – Qualifying statement	"It was due to staff shortages"	Sillars, 1986
86. Analytic Remarks – Solicitation of disclosure	"What were you thinking of?" or "Is something going on here?"	Sillars, 1986
87. Analytic Remarks – Solicitation of criticism	"Why does this bother you?"	Sillars, 1986
88. Accounts - Quasi-theories	Adages and simple explanations "It's Murphy's Law!"	Folger, Poole & Stutman, 1997
89. Accounts - Remedy	Offers of reparation "Would it help if I paid for it?"	Folger, Poole & Stutman, 1997
90. Accounts - Conversational Repairs	Corrects or restates issue "What I said was that I was not going to come."	Folger, Poole & Stutman, 1997
91. Accounts – Excuses – Denial of intent	"It was an accident"	Semin and Manstead, 1983
92. Accounts – Excuses – Denial of violation	"I was tired"	Semin and Manstead, 1983
93. Accounts – Excuses – Denial of agency	"It wasn't me"	Semin and Manstead, 1983
94. Accounts – Storytelling and analogies	"I am reminded of a situation" or "Let me tell you a story similar to this problem."	
95. Personal Idioms – Expression of affection	"Now there, there"	Bell et al., 1987
96. Personal Idioms – Request	"Let's get back on track" or "Don't keep me in the dark"	Bell et al., 1987

Appendix P

Explanation and example of face tactic visual summary of a conflict theme

Example: Visual Summary of Face tactic - Since When is that OK.



Explanation: Visual Summary of Face tactic - Since When is that OK.

The above diagram summarizes the face tactic used in the interaction from the first conflict theme: *Since when is that OK*. This figure presents four of eight different interactions, each from one of the 94 stories told by the 24 nurse participants. Each interaction is represented by a group of blocks and displayed in a flowchart format. Individual blocks represent the face tactics associated with the actual comment or response of the nurse. The heading above the blocks explains if the comment is derived from the nurse telling the story or from the offending nurse in the story. To attain the face tactic in each block, the listing of face tactics displayed in Appendix O was used.

The visual summary was created to spare the readers from having to read through the excessive supporting dialogue that gives evidence to the selection of face tactics for each interaction. Therefore, the visual summary is exactly what the name implies, a visual diagram through a flowchart of each interaction in the theme. Each block in the flowchart represents only the face tactics of the interaction and not the combined dialogue of the interaction. In an effort to simplify the process and the appearance, selected blocks in the visual summary have been bolded, colored or shaded. This was done to highlight events where specific or similar face tactics repeated themselves within the conflict theme stories.

The Blocks

"She said 'I don't have time to go to the Nurses' station to get a Tylenol and come back.'" (From the story told by Jane)

The content of each block in the visual summary provides a systematic listing of the nurse's face tactic. As displayed in Appendix O, all face tactics fall within one of two

macro level categories, defensive or restorative, as based upon the scholar that originally identified and defined the face tactic. This is listed in the blocks as the first line of text.

Restorative

The second line in the block comes from the categorization of the face tactics using one of the Blake and Mouton (1964) and Thomas and Kilmann (1978) conflict-management styles. These styles: competitive, collaborate, compromise, accommodate and avoid further identify a category for each of the face tactics supplied by the theorists in Appendix O.

Restorative Competitive

The third and succeeding lines the face-tactics classifications, as identified by the founding theorists, are listed. Inductively from the last line in the block (5^{th}, but may be 3^{rd} or 4^{th}), all other lines are completed from the data in Appendix O by the researcher. At lines 3, 4 and 5 there is no categorization on the part of the researcher. The theorists' face tactic is identified and inserted into the block. An example of the block text and matching participant's excerpt would be:

Restorative Competitive Account Justification Appeal to Utilitarianism

Therefore, the block represents the quotation:

“She said ‘I don’t have time to go to the Nurses’ station to get a Tylenol and come back.’”

Restorative – Competitive – Accounts – Justification – Appeal to utilitarianism

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